Community Planning Group
of Southern Nevada (CPG SoN)

State of Nevada
HIV Prevention Plan
2003 - 2005

(Revised: August 7, 2003)

Northern Nevada
HIV/AIDS/STD
Planning Council
NNPC

ACKNOWLEDGEMENTS

The Nevada HIV Prevention Plan is a community effort. A nearly endless list of both individuals and organizations contributed to the community planning process, and although there is not room to thank everyone individually gratitude goes out to each person and every organization that participated in the process.

Members of the Community Planning Group of Southern Nevada (CPG SoN) and the Northern Nevada Planning Council (NNPC) were the central factors and the driving force behind this planning process. Each group provided strong leadership within the CPG SoN and NNPC via the Co-Chairs. Community members provided invaluable insight and guidance to the community planning process in Nevada. The support of both public and private organizations was also a part of the strong community-base, which created a successful planning process. Regardless of whether they were being officially represented and, in some cases even without a direct affiliation with HIV prevention services, organizations contributed their staff members, allowing them to be involved in the CPG SoN and NNPC.

The principal consultant for the HIV Prevention Planning process was Carol Maytum, MPH, who coordinated the work of the planning and advisory groups, committees, and technical consultants. She worked in conjunction with the Co-Chairs to plan and facilitate the meetings and produced the *Nevada HIV Prevention Plan*. Gretchen Summerville carried out meeting arrangements, logistics and other coordination tasks essential to the functioning of the planning process for the NNPC and Jason Butts did the same for the CPG SoN. Other assistance was provided by staff volunteered by the Clark County Health District (CCHD) AIDS Office the Washoe County District Health Department (WCDHD) and the Nevada State Health Division (NSHD) Bureau of Community Health. CCHD, WCHD and NSHD provided technical assistance, information, charts and graphs.

The needs assessment team was selected and coordinated by Carol Maytum, of Carol Maytum Consulting Services (CMCS), and included Mireya Bustamente-Brogan, Nancy Downey and Paul Shapiro. Bill Hanagarne conducted the evaluation of the planning process and was selected by CCHD. Individuals who participated in group and individual interviews provided critical information to the needs assessment process. Many community based organizations (CBO's) volunteered hours of assistance to the project. Dina Hunsberger provided invaluable assistance pertaining to process and outcome evaluation for activities described in the Plan.

Much of the structure of this planning process came from the work previously done by the Centers for Disease Control and Prevention. Assistance from the CDC by way of Project Officers Sean Griffiths and Tomas Rodriguez was extremely helpful as members plodded along in the arduous planning process.

Public participants at meetings, participants in the needs assessment, and many additional community members provided support, comment or contributed information, all of which broadened the planning process.

The Nevada Comprehensive HIV Prevention Plan is dedicated to all members of the Nevada Community Planning Group, to those who are living with HIV, to those who have died from complications of AIDS, and to those who work tirelessly to prevent further HIV infections.

NORTHERN NEVADA COMMUNITY PLANNING GROUP -- (NNPC)

McConnell, Sara, M.P.A.	Public Health Co-Chair, Washoe County District Health Department
Taylor, Gwen	Community Co-Chair, A.C.C.E.P.T.
Frampton, Larry	PWA Co-Chair
Abel-Johnson, Cordelia	Community Member
Boston, Mike	Nevada Urban Indians
Dunaetz, Forrest	Frontline of Northern Nevada, PWA
Elder, Carolina	PWA
Felix, Ben	A Rainbow Place
Howell, Jennifer, M.P.H.	Washoe County District Health Department
Katz, Andrea	Northern Nevada Outreach Team, PWA
Kutz, Steve	Washoe County District Health Department
Maldonado, Diana	Nevada Hispanic Services
Mastropierro, Larry	Community Member
May, Steve	Northern Nevada H.O.P.E.S., PWA
Mendoza, Gabrielle	Nevada Hispanic Services
Murchison, Kenya	A.C.C.E.P.T.
O'Grady, Cheryl	Washoe County Social Services – Clinical Social Work
Smith-Ingberg, Lori	Community Member
Summerville, Gretchen	Nevada State Health Division, HIV Prevention
Tellez, Laura	Nevada Hispanic Services
Tollerstad, Nedy	Nevada Hispanic Services

The Vision and Mission of the Northern Nevada HIV/AIDS/STD Planning Council is as follows:

VISION STATEMENT

"With compassion, to improve humanity through effective communication, cooperation and collaboration with the vision of eliminating HIV disease and improving overall health for the community."

MISSION STATEMENT

"To develop a comprehensive and evolving plan that produces leadership and acts as a guide to address quality of life and reduce stigma using effective public health strategies for the community at large."

COMMUNITY PLANNING GROUP of Southern Nevada – (CPG SoN)

Jackson, Thomas	Community Co-Chair, Community Planning Group of Southern Nevada
Moran, Kevin	Community Co-Chair Elect, Caminar
Tonge, Marlo	Public Health Co-Chair, Clark County Health District
Augustin, Christian	MGM/MIRAGE, Community Affairs and Corporate Diversity
Battle, Irene	Sista to Sista
Beisecker, David, Ph.D	University of Las Vegas, Nevada – Philosophy
Harris, Lydia	F.A.C.T.
Hartl, Alex, Ph.D	Shuffle Master Gaming
Little, Susan	Clark County Social Services
Miller, Graham	The Center (GLBTQ)
Pitts, Yolanda	A.H.E.C.
Prochet, Tanya	Sista to Sista
Radeloff, Cheryl, Ph.D	University of Nevada Las Vegas, Nevada - Sociology
Resnick, Mary	Clark County Health District – Surveillance
Schmidt, Amanda	University of Nevada, Las Vegas – Student, Health Education
Walker, Verna Rae	Community Member
Witt, Sue	University of Nevada, Las Vegas – Nursing Department
Ybarra, Jennifer	Planned Parenthood

The Mission of the Community Planning Group of Southern Nevada is to:

Prevent the spread of HIV infection in Southern Nevada through community participation in a prevention planning process leading to a comprehensive plan assuring effective prevention programs, education programs, and care activities, that are responsive to community-identified needs within defined populations.

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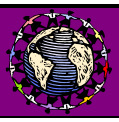


INTRODUCTION

Early in 1995, the National Centers for Disease Control and Prevention (CDC) issued a "Supplemental Guidance on HIV Prevention Community Planning for Non-Competing Continuation of Cooperative Agreements for HIV Prevention Projects". It was this national guidance that was followed in Nevada to initiate and implement the Nevada Community Planning Process for 1999-2001 by the Nevada Bureau of Community Health. The revised guidance directed the planning regions in the South and North to develop and carry out a participatory planning process as a recommended method to build an effective local HIV prevention program and to coordinate with statewide community planning and comprehensive planning activities.

According to this guidance:

> Participatory community planning is an essential component of effective HIV prevention programs. This type of planning is evidence based (i.e. based on HIV/AIDS epidemiologic surveillance and other data, ongoing program experience, program evaluation, and a comprehensive, objective needs assessment process) and incorporates the views and perspectives of the groups at risk for HIV infection/transmission for whom the programs are intended, as well as other providers of HIV related services.
>
> HIV Prevention Community Planning is an ongoing process in which local health departments share responsibility for developing a comprehensive HIV prevention plan with other governmental and non governmental organizations, and representatives of communities and groups at risk for HIV infection or those already infected. Priority setting accomplished through a participatory process will result in programs that are responsive to high priority, community-validated needs within defined populations. HIV prevention programs developed without community collaboration are unlikely to be successful in preventing the transmission of HIV infection or in gathering the necessary public support for effective implementation.

The CDC prevention guidance states the core objectives as follows:

- Fostering the openness and participatory nature of the community planning process.
- Ensuring that the community planning group(s) reflects the diversity of the epidemic in the jurisdiction, and that expertise in epidemiology, behavioral/social science, health planning, and evaluation are included in the process.
- Ensuring that priority HIV prevention needs are determined based on an epidemiologic profile and a needs assessment.
- Ensuring that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost and cost effectiveness, theory, and community norms and values.
- Fostering strong, logical linkages between the community planning process, application for funding, and allocation of CDC HIV prevention resources.

This document represents the work of two community planning groups, the CPG SoN and the NNPC, each having worked diligently from May 2001 through September 2002. The Nevada HIV

prevention planning groups are diverse groups representing populations at risk for HIV, geographic areas, and various ethnic and racial populations in Nevada. The NNPC was established nearly three years ago to provide a forum for individuals with or affected by HIV, those providing AIDS-related services, interested community members, and State Bureau of Community Health staff to work in partnership to plan prevention and treatment services for Nevada PLWH/A and to provide a forum for members to review available information about needs and HIV, prioritize HIV prevention needs, assess community resources to address the HIV epidemic, identify unmet HIV prevention needs, and provide input into a statewide HIV prevention plan.

Nevada is one year behind many other planning groups. Due to the restructuring of Nevada's community planning process as well as many variables that are typical of and expected in local and state government, Nevada was not able to submit a Prevention Plan for 2001. However, in early 2001 both regions initiated many changes that would enable HIV prevention community planning to be a success. At the culmination of this energized process, many believed that the efforts on behalf of staff, community members, general participants and others who could offer advice generated a new paradigm for prevention services. Members believed that the new millennium warranted changes and were eager to implement them. The belief of members and the energy required to fulfill that vision has resulted in a new focus that generated an entirely new view for Nevada HIV Prevention.

This planning process has been a refinement of the last process, which occurred primarily in 1998. It should be noted that some general, yet significant changes to this year's process occurred. They include:

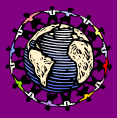
- An emphasis on orientation and technical assistance sessions (on evaluation, needs assessment, epidemiology, counseling and testing, etc.)
- The group(s) approved planning calendars for 2001 and 2002 to facilitate a smoother planning process.
- The group(s) made a commitment be active planners and decision makers and acknowledged the need for third party services to accomplish the necessary tasks.
- Members of each regional group worked diligently to understand and manage conflict of interest within the regional groups.
- Each regional group supported the other regional group in many areas throughout the process to ensure concurrence to a statewide plan.

The usual constraints of time and money meant that not all of the elements of the planning process were as fully operational as would have otherwise been desired. More lead time would have produced a more comprehensive needs assessment and may have generated more participation in the planning process from some of the under represented constituencies. More time and/or more resources to publicize the activities of the planning process may have lead to more public comment and participation. More time for the planning activity would have reduced the intensive demands on the time and energy of participants in the planning process and might have encouraged greater participation or resulted in more opportunities for innovation. Finally, greater resources of time and money might have resulted in a document of broader scope or with more in-depth coverage of the issues concerned with HIV prevention in Nevada.

On the other hand, in a fairly short period of time, a broad-based community planning body was developed and brought together in the South and re-vamped in the North. These groups reviewed and digested a substantial amount of data, research, presentation and planning information. They processed and formulated their own ideas as individuals, through small groups and as a full working group(s). Community needs assessment activities were carried out to be as directly responsive to questions and concerns raised by the planning group process as possible. Consistent evaluation activities were undertaken. Priorities were developed and debated by participants with viable alternatives being presented and compromises being negotiated and agreed upon throughout the process. From this process and the background provided by the Nevada Comprehensive HIV Prevention Plan 1999-2001, the revised HIV Prevention Plan for Nevada is now available.

All those concerned in the planning process recognize these efforts as valuable and an initial step in a much larger planning process that must be on going. Members acknowledge that *planning* efforts are typically defined as a "work in progress". Subsequent planning activities should review the experiences gained in the first year of implementing this plan, changes over time in the epidemiology of the disease, and important social or political changes in the climate in which prevention services are created and carried out. Future plans may choose to emphasize different elements or aspects of prevention and education strategies or modify or change the priorities established in this plan. The critical element is that the process remains participatory in which there is an ongoing commitment to communication and coordination among diverse constituencies. It is this community base that grounds the plan and makes it a viable guide for developing and implementing HIV prevention and education activities in Nevada.

During the 2003 calendar year, the CPG SoN and the NNPC will engage in planning activities as identified in the Nevada HIV Prevention Plan. These planning activities will be evaluated in the following manner: 1) collecting demographic data from CPG members, developing a CPG member database, and producing a directory of CPG members; 2) administering meeting evaluation forms to CPG members at the conclusion of CPG meetings; and 3) conducting an annual CPG member survey intended to assess CPG member satisfaction, perception of progress toward objectives, and the implementation of the Nevada HIV Prevention Plan.



CHAPTER 1: HIV/AIDS EPIDEMIOLOGICAL PROFILE

The Northern Nevada HIV/AIDS/STD Planning Council (NNPC) and the Community Planning Group of Southern Nevada (CPG SoN) have been diligently working, with the assistance of the consultants, to enhance the community planning process in the state and to create and implement an effective Comprehensive HIV Prevention Plan for Nevada.

In order to ensure that priority HIV prevention needs were determined based on an epidemiological profile and a needs assessment, the southern region contracted with Dr. Mitchell Cohen of Partnership for Community Health (PCH). The northern region worked with the State Bureau of Community Health to complete an updated epidemiological profile. Each regional group reviewed the epidemiology data in an in-depth fashion. They requested to review data such as:

- Infection by Modes per Race – Male & Female
- Total HIV/AIDS per Race – Clark County, Nevada
- Out of Care – Male & Female
- African American HIV Positive Percentages by Year of Report
- Living HIV/AIDS Mode of Transmissions by Year of Report
- Top Ten Zip Codes by Mode
- Top Ten Zip Codes by Race
- All Living HIV/AIDS Reports by Year of Report and Gender
- Current Age of HIV/AIDS by Year of Report
- Reported HIV/AIDS in Rural Communities by Modes of Transmission, Gender, and Race per Year
- All Men Tested by Race per Year
- Men Ages 20-29 Tested by Year
- All MSM/IDU by Race per Year
- All Men Tested by Mode of Transmission and Race per Year
- Various Data Reports Generated by HIV/AIDS Reporting System (HARS)

The summary that follows presents the state of the HIV/AIDS epidemic in Nevada, highlighting key differences and trends between demographic and risk groups and geographic regions. The data presented here extract the key elements from two free standing reports: "***Greater Nevada HIV/AIDS Epidemiological Profile 1996-2000***" which covers the Northern Nevada region, and "***Las Vegas EMA Epidemiological Report"*** prepared for the Las Vegas Ryan White CARE Act, Title I Eligible Metropolitan Area. These two reports cover, in more thorough fashion, the epidemic and its impact. This Executive Summary is developed for planners as a place to begin understanding the epidemic. With that understanding, the detailed data in the two reports are available and important tools to be used for informed decision making.

The two detailed reports are available by request from the Nevada State Health Division at 775-684-5900

1. Nevada Socio-demographic Context

Nevada is a unique and diverse state ranging in culture and lifestyle from the 24-hour a day glitter of Las Vegas and Reno, to the solitude of remote ranch life in sparsely populated rural regions. Nevada ranks 7th in the United States in area with 110,540 square miles. While Nevada is home to more than 2 million people, 68.8% live in Clark County, (Las Vegas) in the southern part of the state. The second most populous area is the Reno-Sparks Metropolitan Area located in Washoe County in northwest Nevada (17.0%). Table 1 showing the 2000 populations of Nevada counties illustrates the unequal population distribution.

Table 1: Nevada County Populations 2000

COUNTY	Population 2000	% of Total
Clark County	1,375,765	68.8
Washoe County	339,486	17.0
All Other Counties	283,006	14.2
TOTAL	1,998,257	100.0

Nevada grew 66% from 1990 to 2000 making it the fastest growing state in the country. Twenty five percent of Nevadans responding to the 2000 census lived in a different state in 1995. In addition to people moving into the state, Nevada attracts large numbers of visitors. The Nevada Department of Tourism estimated that in the year 2000 there were more than 48 million visits to Nevada with more than 85% being to Clark County and 10% to Washoe County. The rapid growth and high population turnover contribute to a complex HIV/AIDS epidemiological picture with many PLWH coming to the state after being infected. One implication of that fact is the strong possibility that there are many unidentified PLWH residing in the state.

Race/Ethnicity Distributions

The race/ethnic distribution of Nevada's population is shown in Table 2. As can be seen, the majority of Nevadans are Caucasian (78.4%). The next largest groups are Hispanics (19.7%) and African Americans (7.5%). More than 90% of African Americans reside in Clark County[1].

Table 2: Race/Ethnicity of Nevada Population, 2000

Race alone or in combination with one or more other races*	#	%
White	1,565,866	78.4
Black or African American	150,508	7.5
American Indian and Alaska Native	42,222	2.1
Asian	112,456	5.6
Native Hawaiian and Other Pacific Islander	16,234	0.8
Some other race	193,720	9.7
Hispanic or Latino (of any race)	393,970	19.7

[1] Nevada State Demographer's Office.

* In combination with one or more other races listed. The six numbers may add to more than the total population and the six percentages may add to more than 100 percent because individuals may report more than one race.

Source: U.S. Census Bureau, Census 2000 Summary File 1, Matrices P1, P3, P4, P8, P9, P12, P13, P17, P18, P19, P20, P23, P27, P28, P33, PCT5, PCT8, PCT11, PCT15, H1, H3, H4, H5, H11, and H12.

Personal Income and Unemployment

In 1999, the median household income in Nevada was $44,581. This was 6.2% greater than for the nation. Reflecting the impact of gaming, recreation and entertainment on the Nevada economy, 26.3% of employed Nevadans worked in those industries. The June 2002 unemployment rate was 5.5%, slightly lower than the 5.9% for the nation as a whole.

2. Impact of HIV/AIDS on Nevada's Population

Ethnicity, Gender and Age: As shown in Table 3, in 2000, Nevada had 282 reported AIDS cases and 304 HIV (not yet AIDS) cases. The general population AIDS rate was 14.1/100,000. The AIDS rate among African Americans was 3.5 times the rate in the general population. The rate among Latinos is less than the general population rate, but the general population rate is substantially affected by the high rate among African Americans. The AIDS rate among Caucasians, who comprise the majority of Nevadans, was less than the general population AIDS rate but because the population is primarily Caucasian, the majority of HIV infections and AIDS cases continue to be among Caucasians. Because Asians and Native Americans had only 5 AIDS cases and 6 HIV cases among them, rate comparisons are not appropriate.

Table 3: Nevada HIV and AIDS Cases by Ethnicity 2000

	Population	AIDS	AIDS Rate*	% of All AIDS	HIV	HIV Rate*	% of All HIV
Caucasians	1,501,886	163	10.9	57.8	174	11.6	57.2
African American	135,477	66	48.7	23.4	72	53.1	23.7
Hispanic/Latino (any race)	393,970	48	12.2	17.0	52	13.2	17.1
Asian	90,266	4	-	1.4	4	-	1.3
Native American	26,420	1	-	0.4	2	-	0.7
Nevada		282	14.1	100.0	304	15.2	100.0

Sources: Nevada State Health Division Surveillance Branch
US Census 2000
Centers for Disease Control HIV/AIDS Surveillance Report June 2000

* Cases/100,000 population

Note: The population estimate for Hispanic or Latino uses data from the 2000 census, which allowed individuals to specify both race and Hispanic origin, whereas the HIV/AIDS designation requires a choice of ethnic designation. As a result, the Hispanic/Latino population is a slight overestimate and calculations of Hispanic/-Latino AIDS and HIV rates are slight underestimates.

Table 4: Nevada HIV and AIDS Cases by Gender 2000							
	Population	AIDS	AIDS Rate	% of All AIDS	HIV	HIV Rate	% of ALL HIV
Male	1,018,051	233	22.9	82.6	254	24.9	83.6
Female	980,206	49	5.0	17.4	50	5.1	16.4
TOTAL		282		100.0	304		100.0

Sources: Nevada State Health Division Surveillance Branch
US Census 2000

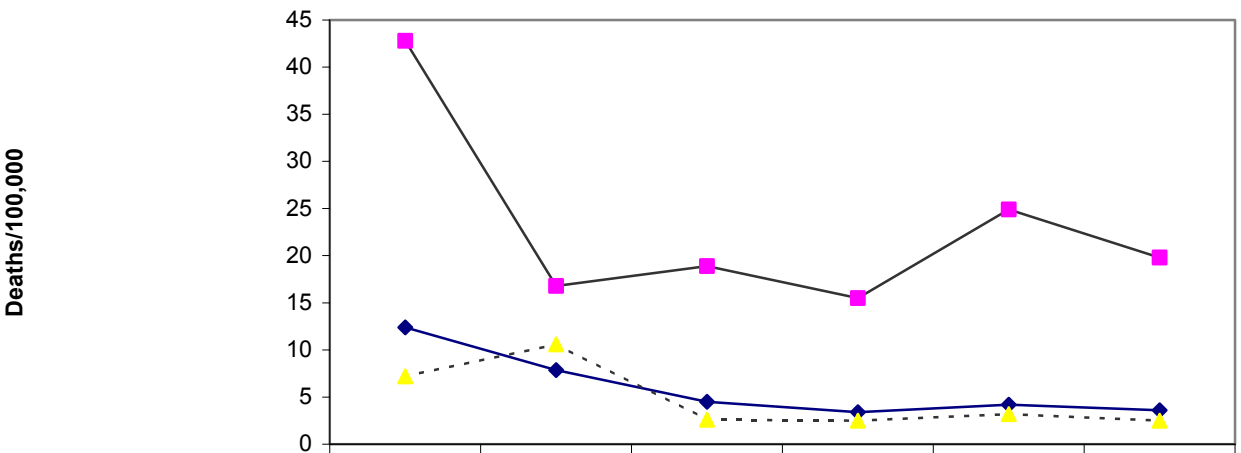
The 30-39 year old age group contained 45.7% of all Nevada AIDS cases reported in 2000. This figure was similar to the 44.7% prevalence found nationally among this age group. As is the case with AIDS, the 30-39 year old age group was the most likely to test positive for HIV (44.1% of all cases reported). This number was higher than the 38.6% found nationally.

Transmission Mode: Of the 282 reported AIDS cases in Nevada in 2000, 167 (59.2%) were acquired through male-to-male sex. This percentage is nearly twice the percentage of AIDS cases among MSM nationally (32.2%). Of the 304 HIV (not yet AIDS) cases reported in 2000 in Nevada, 167 (54.9%) were MSM. The national percentage of HIV (not yet AIDS) cases that were MSM was 29.0%*.

Death Rates: While new therapies can be credited with slowing the progression from HIV to AIDS and from AIDS diagnosis to death, the impact is not observed evenly throughout the population. As shown in Figure 1, the AIDS death rate among African Americans in Nevada is more than five times the death rate among Caucasians and Latinos.

* Based on only 36 states with HIV reporting.

Figure 1: Nevada HIV/AIDS Death Rate by Ethnicity



	1995	1996	1997	1998	1999	2000
Caucasians	12.4	7.87	4.5	3.4	4.2	3.6
African Americans	42.8	16.8	18.9	15.5	24.9	19.8
Latinos	7.2	10.6	2.6	2.5	3.2	2.5

Year

3. Populations at Risk for Infection

The main groups of people at risk for HIV/AIDS in Nevada are as follows:

i. **MSM**: Despite a shift toward other population groups in recent years, as shown in Table 7, MSM are the majority of all recent as well as cumulative HIV and AIDS cases. In particular MSM of color are a growing proportion of PLWA/H. Of the MSM identified as HIV+ in 1992, 32% were men of color while in 2000 MSM of color were 41% of MSM newly identified as HIV+.

ii. **Heterosexuals** continue to be a significant risk group comprising 13.5% of new HIV cases in 2002. The proportion of heterosexuals receiving an AIDS diagnosis is also increasing relative to their cumulative proportion.

iii. **Women:** While women comprise 12.1% of cumulative HIV cases, they were 17.4% of new cases in 2000. The absolute number of newly infected women and the rates of infection among women remained fairly constant over the previous five years, while the numbers of cases and rates for men have declined. African American women are particularly affected. As shown in Table 5, in the Las Vegas EMA, females are twice as prevalent among African American PLWH/A as are females of other ethnic groups.

Table 5: Gender and Ethnicity of PLWH in Las Vegas EMA

	Caucasians	African American	Latinos	Other
Female	13.7%	29.6%	11.4%	19.8%
Male	86.3%	70.4%	88.6%	80.2%

iv. Persons of Color: African Americans continue to be disproportionable affected by HIV/AIDS. The rates of infection among African Americans are more than three times the rate statewide (Table 3). Latinos continue to have a rate of infection less than the state as a whole but they are among the fastest growing population of PLWH as previously noted. This is particularly true for Latino MSM.

v. Injecting Drug Users were the second largest risk group after MSM in 2000, but the proportion of new HIV cases among IDUs appears to be declining relative to the cumulative number of cases among IDUs. In contrast to these groups, children have been infected only rarely in recent years. In 2000 only one infant was infected and one developed AIDS. Over the past five years, only seven children under the age of 13 have been infected.

4. Geographic Distribution of HIV Infection

As one might expect from Nevada's unequal population distribution, 85.8% of AIDS cases in 2000 occurred in Clark County, 10.6% occurred in Washoe County, and 3.5% were in the remaining counties. The proportion of AIDS cases in Clark County in 2000 (85.8%) was greater than the cumulative percentages for 1983-2000 (78.8%). This also was true for HIV infections. In 2000, 82.6% of HIV cases were in Clark County vs. 78.8% of cumulative cases. This finding may to some degree reflect the rapid population growth in Clark County; however, it may also mean that the HIV and AIDS populations are growing more rapidly in Clark County. As Table 6 below shows, the incidence of new HIV and AIDS in Clark County greatly exceeds the prevalence's in the rest of the state. The fact that the rates for Washoe County are also greater than for the rest of the state suggests that infected persons are seeking out the state's larger communities. There could be a number of reasons for such a preference including the greater availability of services in Las Vegas and Reno as well as better economic conditions and perceived greater acceptance of HIV+ status.

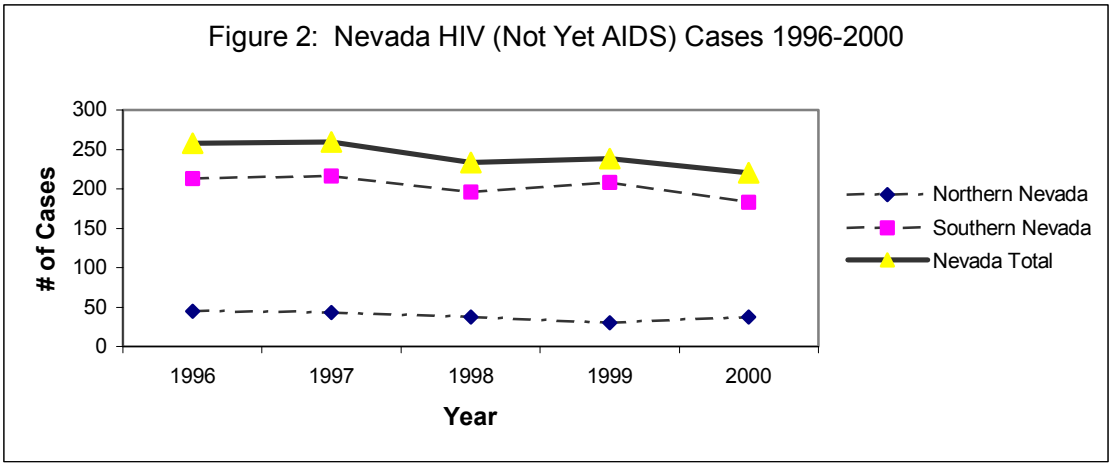
Table 6: Incidence of New HIV and AIDS Cases by Region 2000

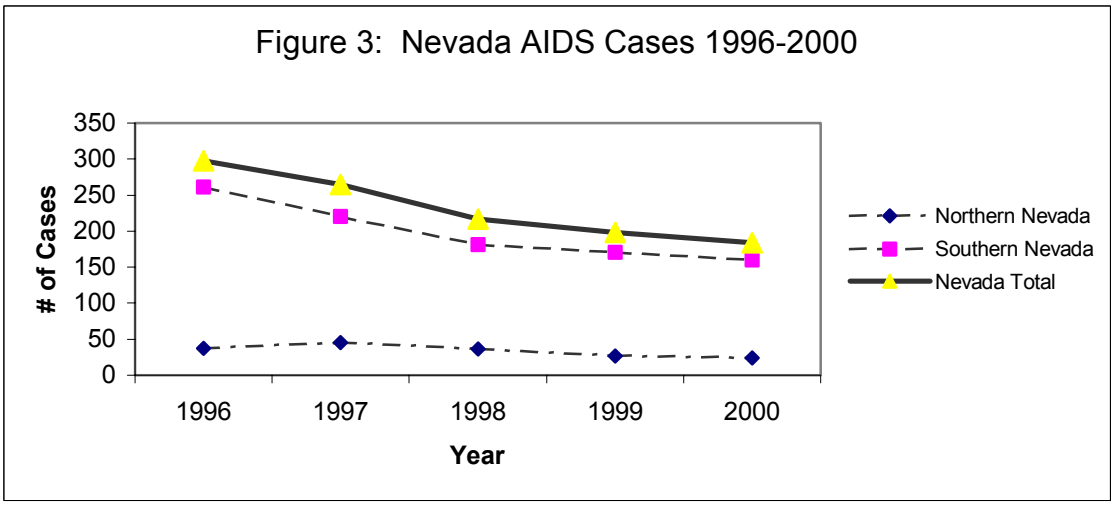
	New AIDS	AIDS Rate*	New HIV	HIV Rate*
Clark County	242	**17.2**	251	**17.9**
Washoe County	30	**8.8**	44	**12.9**
All Other Counties	10	**3.5**	9	**3.1**
State	40	**6.4**	53	**8.4**

* Cases/100,000 population

5. Trends in the Epidemic

As shown in Figures 2 and 3, the overall trend over the past five years has been for fewer HIV infections and fewer AIDS cases. However, observations nationally suggest increased infection rates among MSM, poor adherence to medical regimens, and failures to these regimens suggest that the decline may slow or level off in the next few years.





Source: Nevada State Health Division Surveillance Branch

A picture of trends in the epidemic can be derived from a comparison of recent incidence and cumulative prevalence of HIV and of AIDS (Table 7). HIV incidence by itself tends to predict future AIDS incidence. In addition, substantial differences between any populations past and current incidence suggests a change over time. For example, as shown in Table 7, historically two-thirds of Nevada's HIV infections have been among Caucasians. However, in 2000 that proportion was only 57% suggesting that the rate of infection in the Caucasian population is declining in proportion to other ethnic groups.

In some cases AIDS trends do not match HIV infection trends. These differences may be due to the fact that AIDS incidence reflects infections which occurred up to ten years in the past while HIV incidence reflects more recent events. Alternatively, differences between HIV and AIDS incidence may reflect disparities in access to health care and other variables that directly impact health outcomes. Such disparities in turn are frequently related to socio-demographic variables such as income, language ability and immigration status. The significant trends observed in Table 7 are summarized here.

1. **Geography:** A growing proportion of cases are found in Clark County although, as noted, this apparent increase may be due to more rapid population growth in Clark County. During the period 1986-2000 Clark County's share of the total Nevada population grew from 59% to 69%[2].

2. **Gender**: The current vs. cumulative HIV comparison suggests that the epidemic is decreasing among women although there appears to be a major increase in AIDS among women. As described, the epidemic is still affecting African American women disproportionately.

3. **Race/Ethnicity**: As mentioned, there has been a reduction in the proportions of AIDS and HIV infection among Caucasians. The proportion of AIDS cases among African Americans has increased recently; however, the number of HIV infections among African Americans, though substantially higher than the proportion of African Americans in the general population, is approximately the same as the cumulative rate, suggesting a leveling of HIV infection in this population. The most dramatic change has been the increase in the proportion of HIV infections among Latinos (17.1% in 2000 vs. 11.5% cumulative). The proportion of Latinos who are developing AIDS has also increased substantially over historical levels (17.0% in 2000 vs. 12.1% cumulative). As described above, this trend is particularly apparent among Latinos who are MSM.

4. **Age:** The rate of new infections among those 20-29 has dropped dramatically but has risen among those aged 30 and over. Such a finding might be expected given the effectiveness of new therapies which can substantially delay the progression from HIV infection to AIDS.

5. **Risk**: HIV infection figures in Table 7 appear to suggest increased infection among MSM and Heterosexuals and decreases between IDU and MSM-IDU; however, given the large number of individuals whose risk is not specified, this data must be viewed with caution.

[2] Nevada County Population Estimates July 1, 1986 to July 1, 2000, Nevada State Demographer's Office.

Table 7: HIV (Not yet AIDS) and AIDS Cases in Nevada

	2000 AIDS Cases		Cumulative (1983-2000) AIDS Cases		2000 HIV Cases		Cumulative (1988-2000) HIV Cases		Total 2000 AIDS and HIV Cases		Total Cumulative AIDS and HIV Cases	
COUNTY	**No.**	**% of Total**	**AIDS Cases**	**% of Total**	**No.**	**% of Total**	**HIV Cases**	**% of Total**	**No.**	**% of Total**	**No.**	**% of Total**
Clark	242	85.8	3,482	78.8	251	82.6	2,355	78.8	493	84.1	5,837	78.8
Washoe	30	10.6	681	15.4	44	14.5	502	16.8	74	12.6	1183	16.0
All Other Counties**	10	3.5	258	5.8	9	3.0	129	4.3	19	3.2	387	5.2
Unknown	0	0.0	0	0.0	0	0.0	2	0.1	0	0.0	2	0.0
GENDER	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Male	233	82.6	3,888	87.9	254	83.6	2,447	81.9	487	83.1	6,335	85.5
Female	49	17.4	533	12.1	50	16.4	541	18.1	99	16.9	1,074	14.5
RACE/ETHNICITY	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
White	163	57.8	2,936	66.4	174	57.2	1,887	63.2	337	57.5	4,823	65.1
Black	66	23.4	868	19.6	72	23.7	692	23.2	138	23.5	1,560	21.1
Hispanic	48	17.0	536	12.1	52	17.1	344	11.5	100	17.1	880	11.9
Asian	4	1.4	54	1.2	4	1.3	36	1.2	8	1.4	90	1.2
Native	1	0.4	26	0.6	2	0.7	26	0.9	3	0.5	52	0.7
Unknown	0	0.0	1	0.0	0	0.0	3	0.1	0	0.0	4	0.1
AGE* **	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
<5	1	0.4	23	0.5	1	0.3	24	0.8	2	0.3	47	0.6
5-12	1	0.4	4	0.1	0	0.0	0	0.0	1	0.2	4	0.1
13-19	2	0.7	11	0.2	5	1.6	44	1.5	7	1.2	55	0.7
20-29	30	10.6	727	16.4	68	22.4	1,011	33.8	98	16.7	1,738	23.5
30-39	129	45.7	1,953	44.2	134	44.1	1,252	41.9	263	44.9	3,205	43.3
40-49	67	23.8	1155	26.1	64	21.1	483	16.2	131	22.4	1,638	22.1
50-59	39	13.8	395	8.9	24	7.9	133	4.5	63	10.8	528	7.1
60+	13	4.6	153	3.5	8	2.6	41	1.4	21	3.6	194	2.6
EXPOSURE CATEGORY	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
MSM	167	59.2	2,740	62.0	167	54.9	1,369	45.8	334	57.0	4,109	55.5
IDU	41	14.5	773	17.5	28	9.2	402	13.5	69	11.8	1,175	15.9
MSM & IDU	13	4.6	379	8.6	16	5.3	218	7.3	29	4.9	597	8.1
Hemophiliac	0	0.0	12	0.3	0	0.0	4	0.1	0	0.0	16	0.2
Heterosexual Contact	38	13.5	330	7.5	32	10.5	290	9.7	70	11.9	620	8.4
Transfusion/Transplant	1	0.4	38	0.9	0	0.0	8	0.3	1	0.2	46	0.6
Other	0	0.0	1	0.0	0	0.0	0	0.0	0	0.0	1	0.0
Risk Not Specified	20	7.1	121	2.7	60	19.7	673	22.5	80	13.7	794	10.7
Mom w/ HIV or HIV Risk	2	0.7	25	0.6	1	0.3	24	0.8	3	0.5	49	0.7
Pediatric Transfusion	0	0.0	2	0.0	0	0.0	0	0.0	0	0.0	2	0.0
TOTAL	**282**	**100.0**	**4,421**	**100.0**	**304**	**100.0**	**2,988**	**100.0**	**586**	**100.0**	**7,407**	**100.0**

* By Year of Report.

**The "All Other Counties" category includes the counties of Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine.

***Age is defined as Age at Diagnosis.

CHAPTER 2: HIV/AIDS NEEDS ASSESSMENT

The planning process used in Nevada for developing an HIV Prevention Plan was systematic and comprehensive. It was modeled after the community planning process outlined in the CDC Guidance for HIV Prevention Community Planning. In addition, the *HIV Prevention Community Planning Self-Assessment Tool*, prepared by the Academy for Educational Development for the Centers for Disease Control, was used at the initiation of the process.

The key elements of this systematic process included the following features:

- A broad and diverse representation of the community in the planning process;
- Monthly meetings, conducted for a full day at the same location for five of the seven meetings;
- Leadership from co-chairs, a consultant and facilitator;
- Agendas, ground rules, specific tasks and milestones, and procedures for making complex decisions;
- Ready made "templates" from which to initiate discussion and decisions around priority setting for (1) target populations, and (2) prevention strategies for specific populations;
- A multifaceted needs assessment approach to obtaining, presenting, and generating information that would facilitate the decision making processes; and,
- Evaluation feedback from each meeting, and at the close of the process.

For the most part, these elements served the process well. Occasionally, a member of the planning process would find part of the process objectionable.

Throughout the course of 2002, the NNPC and the CPG SoN worked with the Nevada State Health Division to develop Epidemiological Profiles and Needs Assessment documents that speak to each region and the regional groups planning needs. The State of Nevada served as a provider of Technical Assistance in these areas, acting as the leveraging point for technical assistance contracts, bringing in experts to assist in the development of these documents and as a linkage point between the two regional documents.

In the spring of 2002, efforts by enlisted consultants, with the help of the HIV Prevention Coordinator, and the regional Co-Chairs, were fully underway to complete a comprehensive needs assessment. This provided a description of met and unmet HIV prevention needs in target populations to be reached by HIV prevention interventions, and the barriers in reaching those populations.

Between March and July 2002, Dr. Paul D. Shapiro, Ph.D., created two unique survey instruments, oversaw survey administration, coordinated data management with Downey Research Associates, conducted a series of analyses, and wrote two reports for the Community Planning Group of Southern Nevada and the Northern Nevada HIV/AIDS/STD Planning Council. His work concerned issues related to HIV/AIDS education, awareness, perceptions, prevention, provider services, and actual behaviors as one component of a larger Statewide HIV/AIDS Needs Assessment.

In both northern and southern Nevada, a general public telephone survey and self-administered survey of HIV positive persons were initiated. The statewide survey was randomly administered by telephone to the general public and contained many variables that examined diverse clusters of topics including demographics, health status, public information routes, health district/department involvement, objective knowledge about HIV and transmission routes, subjective risks of contracting HIV, and behavioral status. Information from 603 respondents, proportional to the population of Nevada's 17 counties was collected.

Interesting to all involved, the data collected from the general public survey showed very little variance among responses statewide, with the exception of a few issues. Data also showed that there is a conceptual link between the respondent's knowledge of how HIV is transmitted, their subjective identification of their personal risk for infection, and their decision to engage in unsafe/unprotected behavior. Younger respondents, who are male, non-white, and not living with a partner, are significantly more likely to have engaged in unsafe/unprotected behavior in the past year. In addition, as the respondent's age increased, the probability that the subject engaged in unsafe/unprotected behavior the previous year decreased. Although this is the case, the age that this reduction takes place does not seem to drastically influence behavior until the respondent is into their early to mid forties. Thus, a key finding of the general public needs assessment survey shows that since many of Nevada's prevention programs seem to target younger, more at risk individuals, the probability of engaging in unsafe/unprotected behavior does decrease with age, although marked decreases may not actually occur until later in life than was previously believed.

The other survey was a self-administered instrument, made available to HIV positive respondents, in a non-randomized manner at a few selected provider locations in the Northern and Southern regions of the state. The survey developed by consultants contained many variables examining a wide range of HIV-related issues including demographics, medical care, mental health care, overall health care status, public information routes, health district/department involvement, services utilized, prevention programs that are successful and unsuccessful and behavioral status. Information from 311 respondents was collected, with 78.1% from southern Nevada and 21.9% from northern Nevada. Seventy-nine percent (79.0%) were male, 1.7% identified as transgender and 54.8% were identified as either homosexual, bisexual or some other sexual orientation. Forty-four and four tenths percent (44.4%) of the sample was white, with 36.1% black and 19.5% Hispanic and other.

The key findings from the HIV positive persons survey show that a large percentage of HIV positive persons believe that there was nothing the health districts/departments could have done to prevent their infection. Also discovered was that a large percentage of HIV positive persons are still engaging in unsafe/unprotected behavior and that upon further examination of sub-populations and groups, there are very few demographic differences or regional differences between the HIV positive respondents.

There are many crucial and highly important findings from the comprehensive needs assessment conducted in Nevada. A clear understanding can only be accomplished by a thorough examination of all reports and detailed findings. The needs assessment findings have affirmed that information alone may motivate some to adopt and maintain safer behaviors; however, it often is insufficient. It must be supplemented by community and interpersonal networks that support safer behaviors and with programs that present strategies for safer sex. It is important to make the tools for safer

behavior accessible and available – condoms and clean needles, as well as advocating postponing sex and abstinence from drugs and risky sexual behavior. The challenge has been to design culturally appropriate messages and to work within the cultural context of the various communities in southern Nevada. Recognizing the cultural diversity and information dissemination and logistical needs of the various communities is an essential step, and conducting a series of action research to hone prevention strategies could lead to more effective prevention by those at risk of HIV.

The needs assessment consultants made oral presentations to the regional groups at the August meetings, followed by written reports. The data from these epidemiological reports consisted of both written and oral presentations, with many graphs and charts to illustrate statistical trends of HIV and AIDS. These were submitted to the regional groups at the July meeting, and the epidemiologist meetings to respond to residual questions from participants. The service provider survey results were presented in preliminary form at the July meetings, while follow-up calls were continuing to increase the response rate.

A summary of the needs assessment findings begins on page 16.

The two detailed reports are available by request from the Nevada State Health Division at 775-684-5900. They are also available online at: http://www.downeyresearch.com/HealthReports

Needs Assessment Summary PART I – Survey Research/Key Findings

General Public Findings

If there is one most important finding from the General Public study, it must be the realization that regardless of the number of education seminars, interventions, and prevention programs made available, some proportion of the population is still going to engage in unsafe/unprotected behaviors. The data reveals that there is a conceptual link between the respondent's knowledge of how HIV is transmitted; their subjective identification of their personal risk for infections; and their decision to engage in unsafe and unprotected behavior(s). If respondents are already knowledgeable about how HIV is transmitted; if they are capable of identifying their individual risk status; and yet, they still report engaging in unsafe/unprotected behaviors, perhaps responsible agencies should acknowledge this reality and adjust their prevention efforts accordingly.

Younger respondents, who are male, non-white, and not living with a partner are significantly more likely to have engaged in unsafe/unprotected behavior(s) in the past year. As the respondent ages (gets older) the probability that they engaged in unsafe/unprotected behaviors the previous year decreases. Utilizing more sophisticated statistical techniques, (discussed in the report), in order to hold the independent influence(s) of other demographic variables constant, we were able to discover that while increases in age resulted in a decrease in high-risk behavior, the age that this reduction "kicked in" did not seem to significantly influence behaviors until the respondent was into his or her early to mid forties. Since many prevention programs seem to target younger, more at risk individuals, it may be important to remember that while the probability of engaging in unsafe behaviors does decrease with age, significant decreases may not actually begin until later in life than previously thought.

HIV Positive Findings

The three most important findings from the HIV positive persons study are: (1) a large percentage of HIV positive persons believe that there was nothing the health districts/departments could have done to have prevented their infections; (2) that a large percentage of HIV positive persons are still engaging in unsafe/unprotected behaviors; and (3) that there really are very few demographic differences or regional differences between the HIV positive respondents when detailed analyses are conducted between sub-populations and groups.

Seventy-three and eight tenths percent (73.8%) of these HIV positive respondents said that when they think back to before they were infected, there was nothing the health districts/departments could have done to prevent them from becoming infected. Many respondents readily admit that they knew the risks, that they were using drugs or alcohol, that they were lacking self-control and/or would not have listened to prevention instructions or advice even if it were (or, in many cases, was) available. Additionally, a large percentage of respondents said there was nothing the health districts/departments can do now to prevent them from infecting others. While some respondents report they abstain, or report they practice safe sex, a sizable percentage reminded us that it is still "the individual's choice."

Which leads to the disturbing finding that 45.1% of the respondents report engaging in unsafe/unprotected behaviors since they were diagnosed with HIV. While some of the respondent's report that they engaged in unsafe behaviors with other HIV positive persons, many of the reasons (excuses) provided by others [respondents] are similar to those utilized by many

individuals who engage in self-destructive behavior: They were using drugs or alcohol; they were in the "heat of the moment;" or that their "partners didn't seem to care;" or that they perceived the risks related to oral sex to be low, and/or within an acceptable range.

Except for the data which shows that homosexual/bisexual/and other sexual orientation respondents in the sample were more likely to have begun engaging in unsafe/unprotected behaviors at younger ages than heterosexual respondents; and that non-heterosexuals are significantly more likely to have engaged in unsafe behaviors following their HIV diagnosis, there are few significant (statistically or socially) demographic or regional differences from within the HIV positive respondents.

Conclusions

As one component of this 2002 Nevada State HIV/AIDS Needs Assessment, these studies of the general public and HIV positive persons provide: (1) a comprehensive look into the lives of those infected; and (2) an examination into the complex social context of HIV/AIDS. As educational programs are developed, as prevention services develop, as knowledge of infection and the impact of the disease on society continue to evolve, studies such as these provide invaluable data. If the health districts and the health departments continue with their desire to organize effective HIV prevention programs, perhaps their efforts will have the greatest chance of success if they are able to work together, coordinate personnel, pool economic resources, and implement statewide services. The data from this study suggests that the HIV positive population may be more homogenous than previously thought. The data also suggests that prevention efforts need to be continued and improved upon for the general public. It is through dedicated, multi-focal, complex analyses, such as those being presented today, that will provide the public health professionals the tools they need so they can achieve the most successful long-term outcome results possible.

Needs Assessment Summary PART II – Focus Group Research

Between June 11 and June 27, 2002, Downey Research Associates conducted a series of focus groups for their client, Carol Maytum Consulting Services (CMCS), [for the Community Planning Group of Southern Nevada and the Northern Nevada HIV/AIDS/STD Planning Council] concerning issues related to HIV/AIDS education and awareness. Four focus groups were completed with a total of 36 participants. Twenty-seven Southern Nevada residents (Groups 1, 2 and 3) and 9 Northern Nevadans (Group 4) who were considered to be at various levels of risk for the disease, were asked to share their opinions and provide suggestions concerning HIV/AIDS awareness and education efforts and discuss their experiences and perceptions of personal risk. Their discussions followed a structured moderator script and were observed by the researchers who studied various aspects of their responses and group interactions. This summary provides a general overview of research findings and conclusions based on the combined results of all groups.

A. Participant profiles.

FOCUS GROUP 1: The participants recruited for Focus Group 1 in Las Vegas were 10 men who have sex with men. They varied in age (Range = 23-51; Mean age = 31), education, and racial/ethnic background (Latino = 2; White = 6; Mixed = 2). Most were acquainted before the group began and already had extensive knowledge on these issues as well as a sincere interest in

the research subject. Seven of the men were diagnosed with HIV/AIDS, and all had been tested for the disease and had either friends or family members/partners with HIV/AIDS.

FOCUS GROUP 2: Transgender persons who were recruited for Focus Group 2 in Las Vegas were more similar in age (Range = 33-59; Mean age = 37) racial characteristics (White = 8; American Indian = 1), and also knew each other before attending the group. Only one person in this group was HIV positive, but they had all been tested for various reasons and knew friends who were infected. They perceived their risk of becoming infected with the disease as fairly low.

FOCUS GROUP 3: Focus Group 3 in Las Vegas was composed of 8 persons who had a partner or close family member with HIV/AIDS. They were a diverse group, ranging in age from 24 to 47 (Mean age = 33), with 4 males and 4 females. Their education levels and ethnicities were varied (African American = 4; White = 3; American Indian = 1) and they also had many different personal relationship situations. Some were spouses or partners of HIV positive persons while one woman had a child with the disease. These participants did not all know each other prior to the focus group and their level of experience with the disease varied greatly. They most often perceived their level of risk as possible, but not likely.

FOCUS GROUP 4: The Reno group, (Focus Group 4), was designed to combine several different types of individuals who had varied sexual orientations, genders, ages, and experiences with HIV/AIDS. The participants (6 males and 3 females) ranged in age from 16 years of age (with consent of parent who attended group) to 62 years of age (Mean age = 33) and were similar in race/ethnicity (all were White). Three persons were HIV positive and they did not necessarily know each other prior to the group. However, all participants knew someone personally who is HIV positive and thus had a definite interest in assisting with this research.

B. Prevention material for the general public.

FOCUS GROUP 1: Participants were first asked to consider the various ways in which HIV/AIDS Prevention material might be made available to the general public through the health district/department. They discussed which ways would be the most helpful to the public and which would be the least helpful. Focus Group 1 tended to compare the way HIV/AIDS education is presented in Southern Nevada to the way other cities present their messages. It was noted that *"compared to other cities, Las Vegas targets a certain demographic group with prevention information and doesn't get it out to the larger population."* Apathy on the part of both the general public and the gay community was mentioned as a possible obstacle to education efforts. *"No one seems to be interested in doing anything out here (I'm from LA); everyone's gone back into the closet about these situations." "People are very complacent here." "The same way they exploit and advertise women – this is sin city for only certain sins."* They thought the educational materials should be offered to a larger demographic – more to the mainstream. *"Driving home I saw an AIDS awareness poster on a CAT bus stop – it's nice to see it on a public billboard."* Some felt the message should be personalized according to the culture they are trying to attract. *"You have to address the Hispanic community and you have to do it in a certain way." "We have a big gay culture in the Hispanic community – I could see their reaction when I went on the speaker bureau. The reality of face-to-face helps people see it rather than a little poster. Personal stories are the most effective."* Some brought up the point that education seminars were the most effective motivator for learning about the disease risks. *"If you see a person who comes to your*

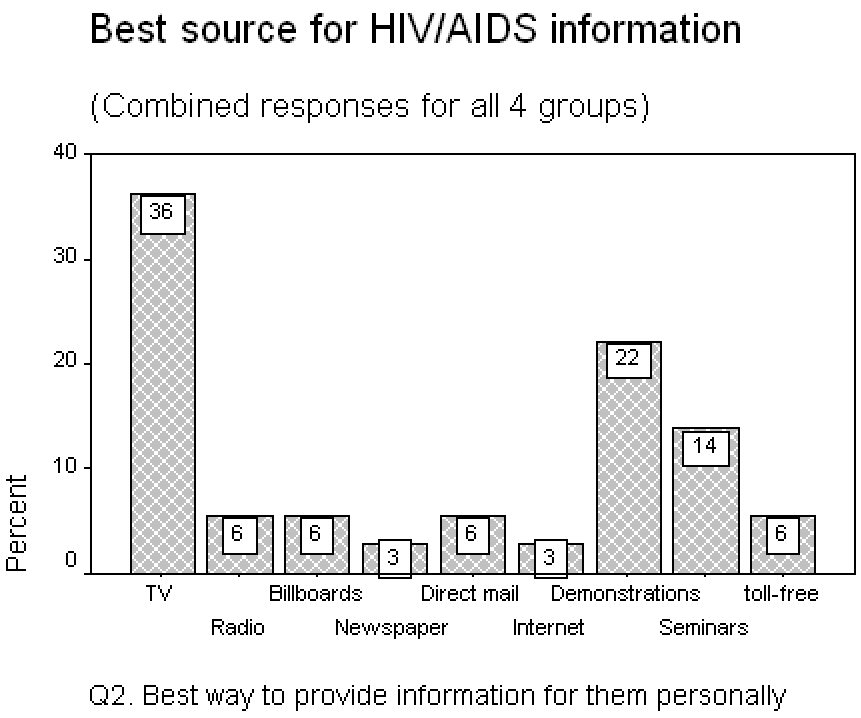
school who can tell you what it's like to live with the disease, put a face on it, it's more effective." "We're all in denial; we think we're invincible, but when we see another person who looks healthy, but could have the disease, you wouldn't know." In the 80's they looked sick and you thought you could tell who had it – but now with medicines, you can't tell right away." "Personally, the human interaction is the most important for learning." Overall, Focus Group 1 felt that television public service ads, demonstrations, information booths at community events, and education seminars were the most helpful ways to reach the general public. Most felt demonstrations were the best way to provide information for them personally and some suggested community-based organizations and face-to-face outreach programs at schools and worksites as effective avenues to disseminate information. *"Develop PR campaigns with blunt facts; put posters in bathrooms at bars; have doctors give information to their patients."* Places like DMV were seen as the least effective route since *"someone might see you reading AIDS information and look at you funny";* suggesting that there is still much to be overcome with regard to the secrecy, fear, and stigma associated with the disease itself.

FOCUS GROUP 2: This group felt strongly that TV public service ads, radio ads, education, and demonstrations were the most effective ways of reaching the general public. *"Use the media where everyone interacts – TV, billboards, radio." "The internet is a good way to reach young people."* When asked what messages would be effective to target the transgender population, some responded: *"The perspective of transgender is really individual – some may feel homosexual and others are straight." "One of the roadblocks is that education to the general public about the transgendered community is so limited that people tend to stay away from what they fear or don't know about." "I already take the HIV prevention messages seriously – you need to target youth. Even if you put it right in front of them they'd say it's not going to happen to me. I wonder at that age if anything would be effective." "Catch them with the message where they are having fun." "Offer them an incentive to sit through hours of education." "I think the lesson is that to market to trans folk you must realize it's a different community than the homosexual community, or the lesbian community."*

FOCUS GROUP 3: Persons in this group tended to feel newspapers, TV ads, demonstrations and toll-free phone information lines would be of greatest value for the general public and for themselves as well. Since these were partners of persons with HIV, their focus was on the information that would be helpful to them in particular, especially more education for family members. *"There is a lot of emotional stress that goes with living with somebody that is HIV positive." "They need to inform us of what to expect and offer more counseling." "When you find out your partner is HIV positive and you're negative the roller coaster ride is emotionally intense on both sides." "My husband tried every possible way to get me to leave him because he was terrified of giving it (AIDS) to me." "The health department needs to stop saying no – we cannot give you any information because it's not you, it's your partner that's HIV positive. That's wrong. I may not be physically positive, but emotionally and mentally I am – I deal with it everyday of my life." "Give the partner a little credit – share information with us." "You live with the odds of being infected day in and day out no matter how cautious you are." "Need information on nutrition, lifestyle, symptoms to watch for with your partner, and emotional support." "Listen to the partners – we know more than you think we know."*

FOCUS GROUP 4: Although the participants in this group were quite varied in many characteristics, they agreed that an effective way to reach the general public would be through the youth. *"Because a lot of people have kids and their kids tell them and it spreads by word of mouth." "Educational seminars for youth – going to the schools and really talking to the kids; At least parents will get permission sent to them at home so they can talk to their children about the disease."* TV and radio ads were seen as important for the public while direct mail was not necessarily the best for everyone.

"Something showing up in my mailbox is something I'm forced to pay attention to." "Anything that's not a bill I throw away and don't even open." "Everyone gets a utility bill – so put some inserts in there – it's safe and non-threatening." "I use the hotlines myself. I needed some information at one time and I was confused and didn't know who to talk to so I used those." They mentioned the importance of having different messages targeted for the general public as opposed to the gay community. Complacency and fear in the gay community was noted and it was suggested that messages should be very direct. *"Let them know that they can't be irresponsible in any way. If you don't know what your HIV status is, you can be irresponsible and put others at risk." "No sugar coating. It has to be told point blank what's going to happen to you if you get AIDS."*



Q2. Best way to provide information for them personally

C. Priorities for involvement in prevention efforts.

FOCUS GROUP 1: Understanding that the health districts/departments have limited funding and resources, participants were asked to prioritize how much involvement they should have in various prevention efforts. Focus Group 1 agreed there should be free HIV/AIDS testing, free condoms, demonstrations and education in public schools; however, they disagreed with the amount of involvement for the other prevention efforts. They were often highly critical of Nevada's public

apathy regarding the disease, administrative policies, allocation of funding, and level of involvement by the corporate sector. *"Provide condoms – absolutely – at more distribution points." "Education, education, education. If you spend the money on education you won't have to spend it on medication." "If they need more money then they need to trim out some of the bureaucracy – that's a major problem in this town." "Educate the bureaucrats – they need to be aware of what we are looking at and how serious this epidemic is." "You can give away all of the free condoms in the world but if you don't educate people on how to use them and where to get them…what good is it?" "Condoms are cheap insurance."*

"They don't give enough of them out at the health department." "They need to reallocate funds – it's cheaper to allocate the money towards prevention rather than paying millions trying to take care of people in the last stages of the disease." "They're sitting back very complacent – the money is drying up – they're going to have another wave of the disease." "There is so much money in this town but the resorts are not giving the money they can afford to give. They don't want to be too closely supportive with HIV and the stigma."

FOCUS GROUP 2: These participants felt the health district should be most involved in free testing, public service ads, outreach and demonstrations, and education in public schools. Providing information at the DMV is seen as ineffective – *"people would not feel comfortable taking information about AIDS to draw attention to themselves." "Employee Unions should be at the bottom of the list – gets caught up with HMO's and government." "Free needle exchange puts the health district at odds with Metro police."*

FOCUS GROUP 3: This group stressed the need for free condoms, free testing, and education in schools. Free needle exchange was seen as least important *"because it's like they are condoning drug use." "Demonstrations (like Coalition of AIDS peer educators) are good to make people comfortable with their bodies – help them understand how to be safe."*

FOCUS GROUP 4: With regard to priorities for health department involvement, their preferences were for free condoms, free testing, education in public schools, and PSA's. *"Free condoms go along with education." "There are very few agencies that are targeting youth. Washoe County is probably the only district in the state that has some sort of sexual health education." "When we had the guy with AIDS come into school, all the girls were crying…all they did was talk about it for a week. All the boys were trying to make it look like they didn't care, but you could tell they did." "There are a lot of financial assistance things that are not offered in Nevada that I had in other states – here there are a lot of doors shutting in my face."* This group stressed the concept that there are many other factors that reduce a person's ability to make informed, safe choices and these need to be addressed along with the general public campaign. *"They should offer more indigent services such as alcohol treatment and drug abuse treatment – that would also help the education process because if you are drunk or high, if you are shooting up, you are more apt to want to hook up with someone and engage in risky behavior."* Targeting minority groups (such as Latino or African Americans) was seen as important and suggestions were made to reach not only bars and hang outs, but specific shopping areas so the message can be tailored to appeal to them directly.

D. Education in public schools.

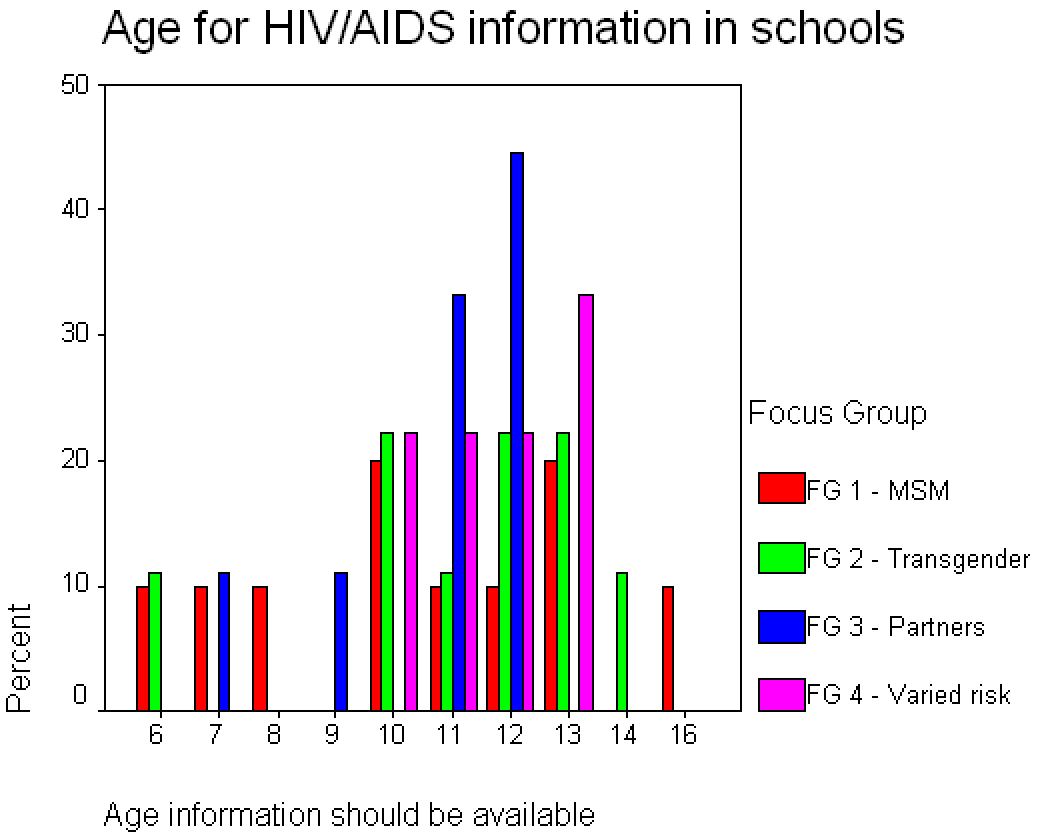
FOCUS GROUP 1: If HIV/AIDS education is provided in public schools, Focus Group 1 believed the information should be made available well before puberty. There was much discussion regarding the age that education should begin, with some saying as early as age 6 and others saying age 13 or 16. As they discussed this issue, those who at first thought children should not receive HIV/AIDS education until they began to be sexually curious, changed their assessment when others said that the information could be introduced as medical information to the very young along with other kinds of disease information, leaving the sexuality component to be introduced at a more appropriate age. *"Mr. and Mrs. Suburbia aren't going to want their 5-year-old educated in Kindergarten." "Children, even at a very young age can be taught simple facts about HIV/AIDS transmission, prevention, etc." "You don't have to talk about sex- as they get older you add more things to it." "Start as early as you can." "Start at age 6 with little pieces of information because we have infants that are HIV positive." "Some professionals don't realize infants can have HIV." "Kids are very aware of everything earlier than you think." "At 13 years old with parents' permission." "We should talk more about awareness rather than education when we are talking about kids."*

FOCUS GROUP 2: The consensus of this group was that AIDS awareness education should coincide with sex education offered in schools at about the age of puberty when kids are experimenting with their sexuality. However, one person disagreed stating: "*It occurs to me that the problem is we have always taught HIV education as part of sex education rather than teaching it as part of biology. It's really an immunology and biology subject and by doing that you can say that it is intellectually interesting and it's less politically charged. It also means that you are more likely to get accurate information at an earlier age because it's science." "Magic Johnson walking around is HIV- gives the wrong impression that he's OK – send the wrong message to youth."* They suggested the health district should focus on peer education programs with an intuitive feel to get the message out and use a dramatic demonstration of statistics. *"Have the people with HIV tell their own stories." "I don't see that it's important to separate transgender persons out from the general population with these messages."*

FOCUS GROUP 3: Again, with regard to the subject of what age children should be taught about HIV/AIDS, participants were divided between introducing it at age 6-8 vs. age 11-12. *"Under age 11 should be educated by their parents with information packets sent home to parents." "Whenever they start getting sexually curious." "Teach them at age 10 before they start to experiment with sex." "Girls can hit puberty at age 10, so it needs to be taught earlier."*

FOCUS GROUP 4: This group saw parental involvement in the educational efforts in schools as vitally important. *"You need consensus from the parents that this needs to be done in our schools so I think we need to start with the parents to go to the school boards to make sure that we have an effective program in the schools."* The consensus was that education is the key to awareness and it is most effective when it shows the realistic "ugly" side of the disease. One woman described the effective educational efforts in Wyoming where 2-4 weeks per year are devoted to intense HIV/AIDS education. *"HIV education began in fifth grade and you got it through high school. They showed movies and brought in people who had AIDS or were HIV positive and had gotten it through different venues." "In the Dallas (Texas) area we used to go in and teach about HIV in the fourth grade classes. You'd be surprised how much kids know." "Kids are having sex earlier now and relations at 10 and 11." "Teachers don't have enough understanding of the disease and*

need education on AIDS awareness themselves." "This type of education needs to be reinforced in colleges as well." Although no real consensus emerged from any group with regard to the age at which HIV/AIDS education should be made available in schools, their discussions of the issues provided many insights.



E. Suggestions for effective programs and education efforts .

FOCUS GROUP 1: The participants in Focus Group 1 mentioned programs such as financial assistance, affordable housing, condom distribution, grants, more convenient locations for CBOs, and better support for the community-based non-profit organizations. *"Should have one stop for all services." "People with HIV need to do too much footwork to find out what is available to them and to then access it."* They also thought that a "scared straight" kind of approach to informing teens of the dangers of the disease would be effective. *"If school kids could see a patient that is in the end stages of the disease…see what the face of death of AIDS looks like." "Put a face on the disease – knowing more people that are infected with HIV works to change attitudes and behaviors. Just the education itself sometimes doesn't trigger people but when you know real people, it's a real crisis." "The scare tactic automatically associates fear versus understanding so I'm against that in education."* There was an acute awareness in this group of the ways in which drug company advertisements glamorize those who are being helped by some medications which sends the wrong message to the public. *"When you see a picture of this gorgeous hunk standing there in perfect shape and says I'm HIV positive- that distorts the reality of the hundreds of people we see in the clinic everyday."* With regard to the Speakers Bureau, it was suggested that *"When we put a face on AIDS… when the people are honest and real then it's*

easier to help people because they see the benefits of behavior changes…and get the message." The lack of HIV/AIDS awareness of the general population was stressed as well as the need for more outreach efforts. *"As opposed to treating this as a gay issue, it really does need to be treated as an issue for everyone…it's a human issue and needs to be in your face, it needs to be on the side of buses…saying AIDS doesn't discriminate." "A lot of heterosexuals and people in there 30's and 40's are clueless regarding transmission." "There is a lot of misinformation amongst a lot of heterosexuals regarding risk." "The danger is a lot of kids think it's an adult disease...that they are safe so they don't get tested or they expect a miracle cure." "The outreach team that actually goes out, takes testing and distribution of materials to what is called non-traditional testing sites has been highly effective." "The Lesbian community and women's groups often step up and get involved with prevention and education efforts in LA. You can't forget that women are infected too – the male community often forgets about the women."*

FOCUS GROUP 2: Participants suggested that there should be more media coverage and more awareness in general about this disease and that we can make a special effort to *"educate the willing."* The point was made that even when people do understand the risks, they often talk themselves into thinking there is not a risk at the time. Information that highlights the statistics associated with the disease and "*tells you what are your chances - that kind of thing catches my eye – makes me stop and read."* They discussed the dangerous kinds of people who would infect others intentionally. *"There are HIV positive people out there who aren't going to tell anybody or get checked; maybe because they're angry and they think I'm taking down as many as I can when I go."* Rather than being a lack of education, some attribute the HIV/AIDS epidemic to *"a lack of paying attention – AIDS is 20 years old and most people know it's there but they don't know how serious it is."* As far as targeting the trans community with awareness messages, most felt that whatever worked for the general population would reach the trans population as well, saying: *"We're so diverse…gay, straight and bi and we are invisible." "There's not necessarily a need to get to a specific group in a specific way – just through the mass media and education." "Bring in community leaders of various types of people – some people will only listen to people who they respect and identify with – someone like themselves" "You need an outreach thing – to say I know where you're coming from – because they're afraid to listen to anyone else." "The only thing that will work with young, promiscuous people is to show them the end product, (people dying with AIDS)." What really got my attention back then was a poster with every race and kind of person represented – showing anyone and everyone could get AIDS. I really sat and looked at the poster and it changed my life."* Something with a strong visual shock effect would be the most effective in a good ad campaign – especially using billboards or commercials during sporting events.

FOCUS GROUP 3: Some in this group acknowledged there may be nothing the health department can do to prevent some people from engaging in unsafe behavior, saying: *"It's what I enjoy; if I'm taking a risk with my life then I guess that's my choice." "I participated in CAPE but I've done things that go against everything I was teaching as a peer educator in that very program."* They suggested using videos, billboards, or pictures of someone that has been infected with HIV because *"sometimes those visuals really have an effect on you." "There should be things out there all the time to jog people's memory to the dangers. What if their partners cheat on them and then they could be exposed." "You can't trust anybody – no matter how much you love that person, they might not even know they have it." "Use shock treatment – show pictures before and after physically so you see what AIDS has done to them." "You can't tell by looking at somebody when they first have the disease so it's deceiving." "Use shocking images – like the*

newest commercial for non-smoking uses babies." Hearing personal stories from people with the disease or knowing someone who died from it seemed to be the most dramatic way to learn about HIV/AIDS. *"Once I actually knew somebody and then they were gone with the disease – that's what really opened my eyes." "Seeing someone deteriorate is very scary." "The best information I ever got was asking one of my friends who had it – it was a safe way to ask them."*

FOCUS GROUP 4: Similar to other groups, participants in this group felt that people will learn most effectively through shock treatment – seeing people die – and emphasized that the speakers who educate need to have experience with HIV/AIDS themselves in order to be believed. *"You need to be going out into the public and saying this could happen to you. There's nothing scarier than to watch somebody with AIDS that wants to die and nobody will help them." "We take kids to see what happens to victims of drunk driving, so why can't we do it with this? Show what happens if you contract AIDS." "Speakers bureau needs to be backed by fears – let them know it's not a death sentence anymore, but there is no cure." "A good solid scare would work for me."* Stressing the difficulties of reaching youth with prevention messages, some younger participants acknowledged that they did not discontinue unsafe sexual practices until they actually were diagnosed with HIV. *"I did what I did. It's not for lack of education and it's not for lack of information. I'm very educated and I've made a choice." "I was brought up in an atmosphere where I knew about risky behavior – I had a lot of knowledge at age 19 – but it didn't matter. Just like her, no poster, no nothing could have stopped me. Being diagnosed HIV positive – that's what woke me up." "They feel they're young and it's not going to happen to me – what can be planted in your head to alter that?" "It's the same with kids drinking and driving. Does it really change them even when they've seen awful accidents?" "You need youth talking to youth." "In my age group, there seems to be a more real fear of pregnancy than the fear of AIDS." "The message should be protected sex doesn't just protect you from AIDS, it protects you from having children and enables you to finish college, to go on to whatever it is you actually want to do instead of becoming a parent. It's probably a more effective message because it carries more immediacy and more a real world impact than if you don't have protected sex you might get AIDS and then it will eventually kill you."* The outreach team programs that go to gay bars and provide free testing were seen as very effective and an example of how private industry can team up with the health district to make a difference in the community and reach more people directly.

F. Conclusions - Similarities and differences between groups.

The group observations clearly show the many different needs as well as differing perceptions with regard to solutions to these complex issues. On the one hand, among gay men and transgender persons, there seemed to be a good deal of intellectual understanding of the difficulties involved with disease prevention efforts as well as a critical attitude toward government and corporate leaders for their apathy and ineffective leadership. *"There is a double-edged sword out there when it comes to HIV. We now have medications that are helping people live longer and look healthier and giving hope…but in turn, that's making the general population think it's no big deal anymore." "Ads you see these days for AIDS patients are not truthful. They look too healthy and vibrant and this is misleading." "Well, obviously, it's going to cost money so we need to make people realize what it's going to take to educate everyone and too bad – this is it. Suck it up! This is the big one!"* On the other hand, others suffer from a lack of specific knowledge about the disease process and support services. Persons who live with partners or family members who are HIV positive are in desperate need of more information with regard to physical symptoms and care-giver advice, as well as emotional support through classes, seminars, or counseling. *"It's like*

a top secret game – the information isn't out there; almost like an exclusive thing or a private club." "All the articles are about the HIV positive person – not the turmoil we go through as partners; we live in torment every day." "The disease doesn't affect just one person – it affects everyone around them." "I just want somebody to understand that it's tough on me too."

The transgender group has shown that this community of persons is often ignored when it comes to HIV/AIDS. *"The transgender community must be addressed by the AIDS community. The trans-population experiences the same risks as many other marginalized populations because they are pushed to the side and have to survive any way they can. And whatever survival skills they can get very often put them at risk. When people of transgender experience seek assistance for HIV/AIDS they are often ignored, mistreated, humiliated and left to die."*

Several important and consistent themes emerged from all groups – that behavior changes are the result of education and that the most effective education comes from sharing personal experiences. The need for state and federal legislative changes was evident *"so they can get their hands untied so they can accomplish what's needed."* The disgrace, secrecy, and stigma associated with the disease has not been erased and can only be changed through early education of youth with targeted messages which are age appropriate and increasing in detail and consistency when they reach the sexual maturity. The knowledge about the disease *"must become part of the culture to a degree – into the mainstream, like accepting inoculations against other diseases– it becomes understood, a given."* There seemed to be much uncertainty over the appropriate age for children to be introduced to HIV/AIDS education either in schools or through parental involvement. As discussion of the issues progressed however, it became evident that there exists a need for a clear division between the biological aspects of the disease and it's specific connection to sexual activities when it comes to educating youth. Children can be taught facts about the disease process, thus reducing fears and negative stereotyping about its victims while allowing more sexually specific information to be introduced at appropriate later stages in the educational plan. The value and effectiveness of shock-type messages was generally accepted and most agreed that hearing the stories directly from persons who suffer with HIV/AIDS and seeing *"the brutal reality and honest portrayals of the disease will have the most lasting effects."*

Although there are a tremendous amount of valuable insights to be gathered from hearing the "voices" of these focus group participants, it is acknowledged that this brief summary can only capture one researcher's analysis. More in-depth review is recommended to determine the full extent of the value contained in this report. This research represents an excellent effort to allow persons directly affected by the disease - those who are courageously struggling to live their lives to the fullest despite enormous obstacles – to become accepted as vital players in the creation of viable solutions to this complex epidemic. As one person expressed it: *"No matter who you are with this disease, you need to be treated as the human being that you are."*

Focus Group Participant Profiles can be found in Attachment 2.

CHAPTER 3: THE RESOURCE INVENTORY

The following information includes the findings from the Nevada HIV/AIDS Prevention Services survey administered to health and social service providers in southern Nevada in March of 2002. The goal of the survey was to collect information to be used in the assembly of a Resource Inventory in preparation of Nevada's application to the Center for Disease Control (CDC) for future federal funding for HIV/AIDS Prevention activities. The CDC requires that each state complete a Resource Inventory as part of the community planning process for determining unmet needs throughout the state. The findings in this report will be compared to those in the consumer needs assessment to determine gaps in prevention services or activities.

Background:
The most recent epidemiological profile[3] estimates there were 4,122 people living with HIV/AIDS in the Las Vegas Eligible Metropolitan Area (EMA) in 2000. The report attributes the decline in new HIV infections from 1992-2000 to the success of prevention efforts. In order to assess the current capabilities among health or social service providers to conduct prevention activities, the CDC requests a Resource Inventory as part of a nine-step planning process to be used by each community planning group. The Nevada Resource Inventory will be compiled using data from the Nevada HIV/AIDS Prevention Services survey (HAPSS).

The HAPSS was written using guidance from the Academy for Educational Development (AED) and the CDC, as well as surveys used by the states of Texas, Florida, and Louisiana. The Community Planning Group of Southern Nevada (CPG SoN) reviewed and contributed to the survey and list of addressees prior to its administration. Addressees were also identified using two resource directories[4], the 1999-2001 Nevada Comprehensive HIV Prevention Plan, and information provided during telephone interviews conducted prior to the completion of the survey. The survey was mailed to 79 providers of health or social services on March 22, 2002. The deadline for completing and returning the survey was April 19, 2002.

Every agency received at least two follow-up phone calls to remind the respondent about the deadline and to ask if help was needed to complete the survey. All respondents were provided contact information in the event that s/he wished to receive a second copy of the survey or ask for assistance. A total of 35 completed surveys were received. Of the 35 surveys received, 13 were excluded due to the respondent's feedback indicating a total absence of HIV/AIDS Prevention activities or funding. A total of 22 surveys have been included in the analysis of this report.

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[3] Partnership for Community Health, *Las Vegas EMA Epidemiological Report* (New York: June 2001). The Las Vegas EMA includes Clark, Nye, and Mohave (Arizona) counties.
[4] HELP of Southern Nevada, *Community Services Directory* (Nevada: Sierra Health Services, Inc., 2001).
Clark County Coalition of HIV/AIDS Service Providers, *Las Vegas Ryan White Title I EMA Resource Directory* (Nevada: December 2001).

It can be noted that at least two other surveys had been administered to health and social service providers in the area during the past 12 months: the 2001 Nevada HIV/AIDS Care Needs Assessment conducted by Partnership for Community Health (PCH), and the CPG SoN Agency Services Survey. This may have contributed to a lack of response among some providers. However, at least 19 providers stated during follow-up that s/he had not completed the survey due to an absence of prevention activities or funding.

Results:
Results of the survey have been divided into the following ten sections with corresponding tables: *(See Attachment three for all relevant tables).*

1. List of Respondents Included in HAPSS analysis
2. List of Respondents Indicating Absence of Prevention Funding/Activities
3. Agency Description and Funding Information (Table 1)
4. Services and Populations Served (Table 2)
5. Client Demographic Information (Table 3)
6. Barriers to Delivering HIV Prevention Services (Table 4)
7. Barriers to Accessing HIV Prevention Services (Table 5)
8. Provider Training Availability (Table 6)
9. Agencies Targeting at least 30% of a Specific Demographic (Table 7)
10. Services Provided to Specific Subpopulations
    Table 8: IDU
    Table 9: Caucasian MSM
    Table 10: African American MSM
    Table 11: Latino MSM
    Table 12: High Risk Females
    Table 13: Heterosexuals
    Table 14: Youth

<u>Table 1 Summary: Agency Description and Funding</u>
Table 1 provides updated contact, agency focus, and funding information.

- Two agencies list HIV Prevention as a primary focus. Five agencies include HIV/AIDS Care/Treatment as part of their primary focus.
- The data show a total of **$1,947,234** budgeted annually for HIV Prevention.
- Nine agencies noted zero funding (but conduct HIV prevention activities/services).
- According to respondents, total HIV Prevention funding sources and amounts for the Fiscal Year 2002 include the following:
  $130,245- City of Las Vegas
  $60,710- State of Nevada
  $364,500- federal sources
  $114,000- private sources
  $25,800- individual donors
  $902,072- sources named “other”.

  Please note that within the “other” category, $826,865 was listed as Ryan White funds and $15,187 was listed as Clark County Health District funds; it is possible that these funds should be listed in different categories.

- The data show two HIV hotlines with one respondent receiving 50 referrals per month from the hotline and the other receiving 3 per month. Another respondent receives 20 referrals per month from the agency website.

Table 2 Summary: Services and Populations Served

Table 2 indicates the providers plans for expansion or reduction in programming, the areas in which its clients reside, services provided, subpopulations targeted, and whether a fee is charged for services rendered.

- Thirteen providers plan to expand their HIV prevention programs. Those planning to expand provide services to clients residing in the city of Las Vegas, Clark County (89106 zip code majority), west and north-central Las Vegas, the eastern part of the city, northwest Las Vegas, and North Las Vegas.
- One provider plans to reduce its HIV prevention programs. This provider serves the "Enterprise" community.
- Of the 18 interventions and 7 subpopulations listed (for a total of 126 possible subpopulation-intervention combinations), six interventions are not offered by any group surveyed. They are: Electronic Media interventions targeted to IDU and Policy Interventions targeted to IDU, White MSM, Black MSM, Latino MSM, and Youth.

Comparisons among the number of providers offering services to the seven subpopulations do not show great disparities in general. (The number of providers providing an intervention to a subpopulation should be considered, in part, in the context of need and provider capacity and not *necessarily* in comparison to how many providers provide that same intervention to other subpopulations.)

Table 3 Summary: Client Demographics

Table 3 provides limited demographic information about clients who access services. Because the actual numbers of clients who access HIV Prevention services are unknown or not tracked separately by providers, the percentage breakdown by race, age, and subpopulation can only be used to analyze individual agency interventions.

Table 4 Summary: Barriers to Delivering HIV Prevention Services

Each agency was asked to rank six barriers to delivering prevention services. The most significant barriers were "Limited funding or staff" and "Funding requirements limit types of services we can provide". These two categories were selected by 11 and 8 providers, respectively, and were noted as the second most significant barriers as well. The barrier "Geographic area too large" was the third most significant barrier overall.

Table 5 Summary: Barriers to Accessing HIV Prevention Services

Each agency was asked to rank eight barriers clients may face when accessing HIV prevention services. "Psychological barriers" and "Social barriers" were the most significant barriers, followed by "Transportation problems".

Table 6 Summary: Provider Training Availability

Table 6 contains information regarding each agency's availability for training and barriers the agency may face in accessing training. Staff shortage, scheduling difficulties, and lack of funding

are the most common barriers to training listed. Nine agencies indicate they do not have a training budget.

Provider Training Needs
Results from survey questions relating to provider training needs will be sent to the University of San Francisco for further analysis and comparison with other states.

The areas in which providers find the greatest need for training are:
- Implementing effective behavioral interventions for clients who are HIV-infected to prevent transmission to uninfected persons
- Integrating planning for HIV prevention and HIV/AIDS care activities
- Developing culturally competent interventions
- Motivating clients to adopt risk-reduction behaviors
- Developing/implementing a gap analysis
- Conducting outcome monitoring of interventions

Table 7 Summary: Agencies Targeting a Specific Demographic
This table may be useful in identifying providers that target a specific age group, race, or behaviorally-defined subpopulation.

Tables 8-14 Summary: Services Provided to Specific Subpopulations
These tables contain all services offered to each of the seven subpopulations listed in the survey. The services have been broken down into the categories within the standard intervention headings of Individual Level, Group Level, Community Level, or Outreach.

A comparison of the interventions offered with the CPG SoN priority rankings reveals the following:

IDU:
On the Individual Level, there are 7-9 providers (32%-40%) offering STD/HIV testing, counseling, and referral services. This is a high-priority area ranked by the CPG SoN.

The CPG SoN also ranks Outreach by Trained Educators and Electronic/Print Media as high priorities for the subpopulation. There are 5 providers (23%) offering the former, and only 2 providers of print media and no providers of electronic media services.

MSM:
On the Group Level, Multiple-Group Sessions and Peer Education Interventions are labeled high priority by the CPG SoN but are offered currently by only 1-2 providers

On the Community Level, HAPSS shows that Community Mobilization Interventions are offered by only one provider to the MSM subpopulation; this is ranked as a high priority by the CPG SoN. Finally, it can be noted that Policy Interventions are ranked medium priority for the MSM subpopulation but are not offered currently by any respondent to HAPSS.

Females-High Risk or IDU (Survey Results compared to both IDU and Heterosexual Partners Priority Subpopulations)

On the Individual Level, there are at least 7 providers (32%) offering STD/HIV Screening and Referral services; these interventions are listed as high priority for the IDU subpopulation.

On the Group Level, there are 4 and 6 providers of Multiple Group Sessions and Peer Education, respectively, to this subpopulation. These services are listed as high priority for the Heterosexual subpopulation.

On the Community Level, there are 6 providers of Clearinghouse services to High Risk Females; this intervention is a high priority for the Heterosexual subpopulation. However, there are very few electronic or print media providers to the IDU community (0 and 2 respectively), and these are high priority interventions.

Heterosexuals-High Risk Males/Females (Survey Results compared to "Heterosexuals" Priority Subpopulation)

On the Group Level, there are 5 providers (23%) offering Multiple Group Sessions and 7 providers (32%) offering Peer Education. The CPG SoN ranked both of these intervention types high priorities.

On the Community Level, there are 5 providers (23%) offering Clearinghouse services to this subpopulation. The CPG SoN ranked this intervention high priority.

Finally, there is just one provider of Policy Intervention services to this subpopulation. The CPG SoN ranked this intervention high priority.

High Risk Youth (Survey Results compared to "Heterosexuals" Subpopulation)

On the Group Level, there are 4 providers (18%) offering Multiple Group Sessions and 6 providers (27%) offering Peer Education. The CPG SoN ranked both of these intervention types high priorities.

On the Community Level, there are 7 providers (32%) offering Clearinghouse services to this subpopulation. The CPG SoN ranked this intervention high priority.

Finally, there are no providers of Policy Intervention services to this subpopulation. The CPG SoN ranked this intervention high priority.

Providers Not Included in Resource Inventory Survey Results

The following list of providers did not complete the HIV/HIV Prevention Services survey:

1. Mash Village
2. St. Rose Dominican Hospital
3. We Can
4. State Health Insurance
5. AARP
6. Charter Hospital Evaluation Team

The following providers returned a survey, but indicated no prevention activities and zero dollars spent on prevention:

1. Nevada Bureau of Alcohol and Drug Abuse
2. ANAC
3. Bridge Counseling Associates
4. Big Brothers Big Sisters
5. Southern Nevada Adult Mental Health
6. Nathan Adelson Hospice
7. American Cancer Society
8. Golden Rainbow
9. American Heart Association
10. Susan G. Komen Foundation
11. Jean Nidetch Women's Center
12. Associated Bilingual Counselors

Virtually every other provider on the original addressee list indicated verbally that it does not provide HIV prevention services and thus did not complete a survey. In a few cases, contact could not be made by mail or phone.

CHAPTER 4: GAP ANALYSIS

The Nevada resource inventory, including data from the Nevada HIV/AIDS Prevention Services Survey, was conducted in spring 2002 by an outside consultant, with assistance from many people across Nevada. The resource inventory includes a description of the existing resources for HIV prevention in Nevada, including fiscal, personnel and program resources, as well as support from public, private and volunteer sources. This process is completed in an attempt to identify HIV prevention programs and activities in Nevada according to the high-risk populations defined in the epidemiologic profile. The NNPC and the CPG SoN reviewed and contributed to the survey and list of addressees prior to its administration. The survey was mailed to 123 providers of health or social services.

Several key findings of the resource inventory, which identify key components of the gap analysis, are as follows: There is limited funding and staff throughout the state. Funding requirements limit the types of services provided. There is a significant need for training in many areas. A greater focus is needed on the number of providers for African American MSM, Latino MSM and Caucasian MSM. Finally, more agencies need to target services to heterosexuals and high-risk youth.

Background:

The purpose of this component of the comprehensive statewide HIV/AIDS Prevention plan is to compare findings from the Nevada HIV/AIDS Prevention Services Survey (HAPSS) with findings from the Statewide HIV/AIDS Needs Assessment Survey of HIV+ persons and the general population (HANAS) in order to identify gaps in prevention services. The former study surveyed 55 providers of prevention services in Northern Nevada to ascertain the types of prevention services provided as well as the client demographics, among other things. The latter surveyed 311 people (243 from the South and 68 from the North) diagnosed with HIV/AIDS to ascertain health status and unmet needs, and 603 people from the general public. The gaps in service were analyzed in the context of the priority-based intervention rankings as identified by the NNPC and CPG SoN. In other words, gaps were revealed by comparing the two surveys, which were then compared to the rankings of the NNPC and CPG SoN in order to prioritize the proposed services.

Summary of Unmet Needs

- Electronic Media interventions targeted to HIV+ and the General Population
- Policy Interventions targeting IDU
- STD/HIV Screening services targeting IDU and HIV+ subpopulations
- HIV/AIDS education in public schools beginning at age 11
- Community-wide events targeting MSM, HIV+, and the General Population
- Print Media and Social Marketing interventions, such as billboards, magazines & newspapers, targeting MSM, HIV+, and the General Population
- Outreach interventions, including condom distribution and needle exchange programs
- Public seminars/presentations targeting MSM, HIV+, and Youth (ages 18-24)

NORTHERN NEVADA:

Gaps in Services by Intervention Type

Gaps in services will be identified primarily by the type of intervention in question, rather than gaps in services within an individual subpopulation. This is due to the findings from HANAS that needs/desires do not significantly vary among subpopulations; however, the samples from HANAS did not include representative proportions of the various subpopulations. In any case, identifying gaps by intervention type may help design more efficient programs that target multiple subpopulations. *Findings from HAPSS on gaps in services provided to priority subpopulations can be found in the Resource Inventory*.

HANAS revealed the following needed/desired interventions or programs reported by the HIV/AIDS community and the General Population.

Individual Level Interventions

Free HIV Testing
In the North, HAPSS reveals that the number of agencies providing STD Screening and/or HIV Counseling, Testing, and Referral depends upon the subpopulation in question. However, it can be said that a larger number of providers offer STD Screening to heterosexuals (33%), high risk females (30%), and youth, (40%). Approximately 7.5 providers (20%), offer these services to MSM, with the smallest number of providers offering services to African American MSM. A larger number of providers (15-16 providers, 40-44%) also offer HIV Counseling, Testing, and Referral services to heterosexuals, females, and youth. However, the differences are small; about 10-13 providers (33%) offer services to IDU and MSM, and the data may simply point to the need for more testing sites in general.

Given that the NNPC has identified Health Education/Risk Reduction within the HIV+ and Partners of IDU subpopulations (High-risk Females used for comparison) a high priority, and Partner Counseling Referral Services within the MSM community a high priority, the addition or increased awareness of HIV testing sites targeting these communities would help to address this need.

The NNPC also labeled Prevention Case Management a high priority across subpopulations. Although HANAS did not produce findings directly linked to this intervention, HAPSS finds 7-12 providers (19-33%), offering this intervention. This area may warrant further consideration.

Group Level Interventions

Education Seminars
This type of intervention falls into the Group Presentation category (a Group Level intervention). HAPSS finds about 16%-33% of all respondents offering Speakers Bureau interventions, with a majority offered to youth and high-risk females. An even lower number of providers (5%-33%) offer Group Sessions, primarily to youth and heterosexuals. These interventions were ranked low to medium priority by the NNPC across subpopulations.

In general, Multiple Group Sessions and Peer Education interventions were ranked a high or medium priority by the NNPC across subpopulations. HAPSS shows the highest number of providers of these interventions in the youth and heterosexual categories, and the lowest number of providers in the MSM category. However, given that the public has identified a seminar format as preferable, this type of Group Level intervention might be considered for future programming.

Community Level Interventions

HIV/AIDS education in public schools

Although this specific type of intervention was not included in HAPSS (it would only be offered by surveyed school districts), it could be classified in two intervention types that were ranked high priority interventions by the NNPC: Policy interventions and Clearinghouse interventions. HAPSS found 1-4 providers of Policy interventions with at least one provider for each subpopulation. However, this is a high priority only within the IDU community, which shows 4 providers; these providers may not direct any activities toward school district policies.

HAPSS found that Clearinghouse interventions were evenly spread across subpopulations but with a maximum of 3 providers for any subpopulation. This was ranked only a medium priority by the NNPC. However, given that HANAS finds that the public seeks Clearinghouses of information on HIV/AIDS, this area may warrant further attention.

Changes to public school curriculum fall outside of the scope of the NNPC's authority and would obviously need to be considered in the context of a change to school district policies.

TV Public Service Ads & Radio Messages

HAPSS finds that there is a maximum of three providers of electronic media services to any subpopulation. The NNPC did not rank this area a priority. Nor did the NNPC identify print media (4-7 providers offer this intervention) as a high priority for the General Population. The NNPC did name social marketing campaigns (3-5 providers offer this intervention) a high priority for the MSM and HIV+ subpopulations.

Respondents in the General Population name these interventions (TV, radio, hotlines, billboards) as the preferred method of receiving information. Given that HANAS overwhelmingly shows public support for electronic (and print media) messages, this area warrants further attention.

Information Booths at Community Events

HAPSS finds 6-9 providers (16%-25%) offering community-wide events to the various subpopulations. The NNPC identifies community-wide events as a low priority. Given public support for this type of intervention, this area may warrant further attention.

Again, HAPSS found that Clearinghouse interventions were evenly spread across subpopulations but with a maximum of 3 providers for any subpopulation. This was ranked only a medium priority by the NNPC. However, given that HANAS finds that the public seeks Clearinghouses of information on HIV/AIDS (information booths at community events, newspapers/magazines, internet*), this area may warrant further attention.

Outreach Level Interventions

Free Condoms
Demonstrations with HIV+ Speakers*
Demonstrations with Outreach Teams*
Work with Employee Unions
Provide information with applications for work cards
Needle Exchange
Provide HIV/AIDS information at the DMV

HAPSS shows 4-7 providers, (11%-19%), depending on the subpopulation, offering Peer Outreach interventions. Given that the NNPC has identified Peer Outreach as a high priority for the HIV+, IDU, and MSM, and a medium priority for Substance Abusers and Partners of IDUs, this is an area in which to focus programmatic activities.

There are more providers offering Outreach by Trained Educators (6-11 providers), although the NNPC labels this a low or medium priority across subpopulations.

Most of these outreach interventions will also require policy interventions/changes first.

Note on County preferences:

- Washoe County is slightly more in favor of billboards and a clean needle program.
- Washoe County is the least supportive of HIV+ demonstrations; 45% think enough programs/services currently exist.
- Rural counties are the least supportive of using the internet to distribute information to the public; rural areas are also less supportive of outreach teams.

SOUTHERN NEVADA:

Gaps in Services by Intervention Type

Gaps in services will be identified primarily by the type of intervention in question, rather than gaps in services within an individual subpopulation. This is due to the findings from HANAS that needs/desires do not significantly vary among subpopulations; however, the samples from HANAS did not include representative proportions of the various subpopulations. In any case, identifying gaps by intervention type may help design more efficient programs that target multiple subpopulations where possible. *Findings from HAPSS on gaps in services provided to priority subpopulations can be found in the Resource Inventory.*

HANAS revealed the following needed/desired interventions or programs reported by the HIV/AIDS community and the general population.

Individual Level Interventions

Free HIV Testing

In the South, HAPSS reveals that the number of agencies providing STD Screening and/or HIV Counseling, Testing, and Referral depends upon the subpopulation in question. However, it can be said that a larger number of providers offer STD Screening to heterosexuals (36%) and IDUs (31%), followed by high-risk females and youth. A larger number of providers (50%) also offer HIV Counseling, Testing, and Referral services to heterosexuals. However, the differences are small (50% compared to 40% for other subpopulations), and the data may simply point to the need for more testing sites in general.

Given that the CPG SoN has identified Individual Level Interventions (Health Education/Risk Reduction) within the HIV+ and IDU subpopulations a high priority, the addition or increased awareness of HIV testing sites targeting these communities would help to address this need.

Group Level Interventions

Education Seminars

This type of intervention falls into two possible categories: Group Presentations (a Group Level intervention) and Presentation/Lectures (a Health Education/Public Information intervention). HAPSS finds that less than 30% of all respondents offer Group Level interventions (Speakers Bureau or Group Sessions) to any subpopulation. The CPG SoN ranked these interventions medium priority.

In general, Multiple Group Sessions and Peer Education interventions were ranked as high or medium priority across subpopulations. HANAS also shows that youth (ages 18-24) ranks Education Seminars as the preferred method of distributing information. Therefore, these types of Group Level interventions should be considered for future programming.

Community Level Interventions

HIV/AIDS education in public schools

Although this specific type of intervention was not included in HAPSS (it would only be offered by surveyed school districts), it could be classified in two intervention types that were ranked high priority interventions by the CPG SoN. They are: Policy interventions within the Heterosexual population and Clearinghouse interventions within the Heterosexual and General Population. HAPSS found one provider (4.5%) of Policy interventions in the Heterosexual Population. HAPSS found six providers (27%) of Clearinghouse interventions for the Heterosexual Population.

Changes to public school curriculum fall outside of the scope of the CPG SoN's authority and would obviously need to be considered in the context of a change to school district policies.

TV Public Service Ads & Radio Messages

HAPSS finds that there is a maximum of two providers of electronic media services to any subpopulation. There are no providers of electronic media messages to the IDU community,

which was identified by the CPG SoN as a high priority. Therefore, this area warrants further attention.

The CPG SoN did not identify electronic media, print media, or social marketing campaigns as priorities for the General Population, yet respondents in the general population do name them (TV, radio, hotlines, billboards). This may be an area for further consideration.

Information Booths at Community Events
HAPSS finds that 27%-45% of providers offer community-wide events to the various subpopulations. The number is lowest for the IDU and MSM communities. The CPG SoN has identified community-wide events within the MSM population a high priority. Therefore, this area warrants further attention.

The CPG SoN also assigned a high priority status to Community-wide events and to Clearinghouse interventions for the General Population; both of these interventions were identified by the general population in HANAS. *(Information booths at community events, newspapers/magazines, internet)*.

Outreach Level Interventions

Free Condoms
Demonstrations with HIV+ Speakers
Demonstrations with Outreach Teams
Work with Employee Unions
Provide information with applications for work cards
Needle Exchange
Provide HIV/AIDS information at the DMV

HAPSS shows a low number of providers (2-7 providers, 9% -32%, depending on the subpopulation) offering Street Outreach activities. Given that the CPG SoN has identified Street Outreach as a high priority for the HIV+, IDU, and the General Population, and a medium priority for the MSM and Heterosexual communities, this is an area in which to focus programmatic activities.

CHAPTER 5: PARITY, INCLUSION & REPRESENTATION (PIR)

The CDC and local CPGs, and the regional planning groups in Nevada know that community participation is a desired and necessary part of community planning activities. As Spiegel notes, "Community participation is the process that can meaningfully tie programs to people" (1968). In fact, Alexis de Tocqueville, in his book Democracy in America observed nearly 175 years ago:

"Americans of all ages, all conditions, and dispositions constantly form associations.... I have often admired the extreme skill with which the inhabitants of the United States succeed in proposing a common object for the exertions of a great many men and inducing them voluntarily to pursue it. "

There are many reasons and actions that lead individuals to sacrifice their self-interests to the public good and consciously link their destinies to those of their contemporaries and descendants. The NNPC and CPG SoN fostered participation understanding that the following two primary principles are critical for long-term success in the HIV community planning process:

1. To generate positive conditions under which communities will participate; and,
2. To provide culturally sensitive and community-oriented approaches which are critical to successfully involving communities in community programs and projects.

“People become involved in community affairs only when certain conditions are present or deficiencies are noted” (Wade 1989, Christensen and Robinson 1980).

Within the HIV community, CPGs function as links between individuals and larger organizational and societal structures. For successful participation to occur there are five advantages that must constantly be noted for active participation in community affairs to occur:

1. The community can bring about desired change by expressing one's desire, either individually or through a community group.
2. The individual learns how to make desired changes.
3. The community learns to understand and appreciate the individual needs and interests of all community groups.
4. The community learns how to resolve conflicting interests for the general welfare of the group.
5. The individual begins to understand group dynamics as it applies to mixed groups.

Within Nevada, public involvement has resulted in better decisions. Community decisions that involve communities are more likely to be acceptable to the local people. Better community decisions, by definition, should be beneficial to the average community.

Community participation in community programs serves to check and balance political activities. Participation allows fuller access to the benefit of all involved.

In hindsight, community participation has also accomplished the following:

*Promotion of dignity and self-sufficiency within the individual;
*Tapping into the energies and resources of individual communities within the community;
*Providing a source of special insight, information, knowledge, and experience, which contributes to the soundness of community solutions.

To be successful in achieving PIR and to have a meaningful Plan, the planning process had two goals. These goals addressed:

(1) The composition and representativeness of the planning group; and,
(2) The comprehensiveness of the needs assessment component to assure informed decision - making regarding target populations and selection of interventions.

- ✓ ***To insure parity, inclusion, and representation in the work group and it's planning process***

As noted above, one of the most critical features of any community-based planning process is to insure that the "community" is represented adequately. The CDC guidelines assert *"participatory community planning is an essential component of effective HIV prevention programs."* The guidelines also acknowledge that the planning process is ongoing, and a collaboration between local government, community-based organizations, and communities or groups at-risk for HIV infection or already infected. The collaborative process permits the use of national and local data in combination with personal experience, anecdotal reporting, and otherwise undocumented "data" to tailor an HIV prevention plan that is both a reflection and a product of the community to be served.

Beyond the detailed documentation of community representation for the CPG SoN and NNPC, it is important to acknowledge the in-kind contribution of various agencies and organizations that permitted their staff to attend meetings each month. While this contribution might be anticipated, or even expected from HIV/AIDS service providers, some organizations with no direct affiliation with HIV/AIDS endorsed the participation of employees as a demonstration of community involvement. This feature of both regional groups illustrates the depth of community participation in the planning process in Nevada.

The staff and consultant to the CPG SoN and NNPC used several strategies to assure parity for the regional groups. One full meeting was devoted to orientation and each meeting had time devoted to information sharing. They were careful to provide written information, in the form of a three-inch binder which contained guidelines for the process, structure and governance, HIV prevention strategies and interventions, data and research, needs assessment information, excerpts from other Prevention Plans, evaluation information, and literature resources. In addition, there were presentations to the regional groups regarding the epidemiology of HIV and AIDS, various prevention strategies and active prevention efforts in the community, and summaries of needs assessment findings.
Each regional group systematically sought to develop planning bodies to meet the needs of the community in developing an HIV prevention plan. In the South, the Clark County Health District reviewed the composition and purposes of existing HIV/AIDS planning groups. After evaluating

the advantages of forming a new group, a decision was made to do so. A newly formed group would maximize the ability to draw upon experience and expertise from the broadest representation of existing groups, to reach into the community, and to provide specific goals, objectives, and tasks.

The primary goal for the creation of a new planning group, the CPG SoN, was to develop a group that matched the local demographics, including representatives from the most at-risk groups or populations, and engaging individuals with a depth and breadth of experience and expertise relevant to HIV prevention and community planning. They sought to bring this composition into reality by casting a wide net for notification and solicitation, using the methods listed below:

*Letters of invitation, flyers distributed, with application forms given to 35 individuals
*Advertisements in four local newspapers
*Seventy-five (75) posters distributed to strategic locations
*Announcements at meetings and events, with distribution of applications
*Telephone calls to representatives of key constituencies

In the North, the NNPC was an established group, with years of history. With this history came significant politics, bias, and perhaps conflict. To remedy this, the NNPC decided to revise by-laws, expand membership, and bring in new members. At the beginning of the planning process the group consisted of 15 voting and 17 non-voting members and at the end they had nearly 25 active participatory voting members.

The staff of both regional groups notified selected applicants by mail, with follow-up telephone calls, to advise them of their acceptance as a member of a planning group. Some candidates were unable to accept the responsibilities. Those not selected were notified accordingly, and informed that their applications would be "held" in the event that a further selection process was needed to fill a particular gap or need.

Forms for applicants included several criteria to enable the selection panel to target specific populations for representation in the group. The "Perspectives Checklist" included questions about gender, age, cultural/ethnic identification, constituency, and type of agency or service provider. Although this information was entirely voluntary, most applicants completed the perspectives checklist. The reviewers also took into account geographic representation, given the high concentration of at-risk populations in specific areas of the community.

Membership grids that document PIR can be found in Attachment 4.

CHAPTER 6: PRIORITIZING TARGET POPULATIONS & INTERVENTIONS

Over a period of several months, both regional planning groups worked to prioritize populations and interventions. Using data and information made available to them, the members prioritized populations at high risk for HIV in Nevada, and then set out to prioritize culturally and linguistically appropriate individual, group and community-level strategies and interventions to reach each population. Various criteria were considered in the prioritization process.

The Northern Nevada HIV/AIDS/STD Planning Council prioritized their populations, each including various gender/race/ethnicity specific subpopulations, as follows:

1. HIV positive individuals
2. Intravenous drug users (IDUs)
3. Men who have sex with men (MSM)
4. Partners of intravenous drug users
5. Substance Abusers
6. Sexually active heterosexuals

The Community Planning Group of Southern Nevada prioritized their respective populations, each also including various gender/race/ethnicity specific subpopulations, as follows:

1. HIV positive individuals
2. Men who have sex with men (MSM)
3. Intravenous drug users (IDU)
4. Heterosexual partners
5. General population

As already noted, the planning process had two goals. These goals address: (1) the composition and representativeness of the planning group; and, (2) the comprehensiveness of the needs assessment component to assure informed decision-making regarding target populations and selection of interventions. This chapter addresses that second goal.

- ✓ ***Assure the comprehensiveness of the needs assessment component to facilitate informed decision-making regarding target populations and selection of interventions***

The needs assessment process applied several methods of data collection, including review of existing quantitative data, conducting a mail survey to 123 agencies and service providers, interviewing key individuals/experts, and conducting group interviews with selected populations about which there was little to no quantitative or supporting data.

Throughout the entire planning process, the members of the regional groups identified and expressed informational needs that were relayed to the needs assessment consultant team. The process of formulating questions began at the beginning of the process when the lunch break was

used to generate discussion of needs assessment questions at each small group table. The group developed a list of numerous questions that applied to the needs assessment. The questions were grouped into the following categories of inquiry:

1. What information is currently available about HIV prevention strategies?
2. What information is needed to identify and address the needs of special populations?
3. How is HIV prevention information disseminated?
4. In addition to information dissemination, what other prevention strategies do the work group want to consider?
5. What prevention strategies address training and education for service providers and educators?
6. What are the policy and funding issues related to HIV prevention?

These questions became the basis of the full needs assessment process, including presentations of data from the epidemiologist, references to reading material in the regional groups binder, presentations from various members of the regional groups, and solicitation of additional information from the community via survey and or interviewing.

In addition, the project consultants drafted a written survey which was mailed to more than 120 agencies throughout Nevada . The questions in that survey sought to obtain information about local services addressing HIV/AIDS, including numbers of clients served, estimated clients at-risk of contracting HIV, identification of the most prominent service providers based on referral choices identified by agencies, current HIV prevention services, and prevention priorities for expansion or initiation. Survey respondents also identified unmet needs and anticipated or existing needs for technical assistance.

For the needs assessment process in general, the process for differentiating between “must know” and “nice to know” questions for the purpose of identifying priorities was informal and relatively spontaneous. Essentially, the needs assessment consultants made every attempt to be responsive to inquiries from members of the regional groups throughout the planning process. Decisions to scale back on inquiries were largely due to acknowledgment of limited time and fiscal resources, or by default when attempts to reach designated groups or individuals were unsuccessful.

Invaluable to the regional groups planning endeavors has been a series of AIDS Action HIV prevention guides (for Youth, Substance Users, Incarcerated Populations, Women of Color, and Gay Men) developed for AIDS Action by AIDS Alliance for Children, Youth & Families and produced by AIDS Action Foundation with support from the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). AIDS Action is the national voice on AIDS.

The numerical rating process used by each group to assess and rank target populations proved to be invaluable. Given this process, there were undisputed high priority populations that received the highest ratings. There were some groups that were rated moderately high. And there were a few groups that received lower ratings, simply due to the low prevalence or unknown prevalence of HIV in that population. The latter two groups provided the basis for discussion within the group about where to differentiate between high, medium, and low priority for target populations.

Seven criteria were identified for the group's consideration, accompanied by a percentage of weighted value for the criteria in the decision process. This rating process was confusing to many of the regional group members, as they worked through it but they finally concluded that they endorsed the proposed weighting and would use it qualitatively in considering ranking of strategies according to whether they were high, medium or low priority.

The full regional group(s) reviewed the final summary of the strategies selection process. The full group agreed with most of the recommendations, and resolved the few remaining discrepancies in discussion.

The rating processes for selecting target populations and prevention strategies were the major by-products of the planning process. They were the most time consuming, required the most concentration and thoughtfulness from members, and aroused the most discussion. Much of both processes occurred in small groups. In conclusion, feedback from participants revealed this was the hard work of the planning process. It also revealed the members who were still attending and actively involved were pleased with the result of their collective efforts.

Members considered various criteria during the prioritization process and were able to arrive at a 'high' ranking for specific interventions based on deductions from the following criteria:

1. *Documented HIV prevention needs based on the current impact and trends of HIV/AIDS and other STDs in defined populations in the health department's jurisdiction;*

2. *Outcome effectiveness of proposed strategies and interventions (either demonstrated or probable);*

3. *Available information on the relative costs and effectiveness of proposed strategies and interventions (either demonstrated or probable);*

4. *Sound scientific theory (e.g., behavior change, social change, and social marketing theories) when outcome effectiveness information is lacking;*

5. *Values, norms, and consumer preferences of the communities for whom the services are intended;*

6. *Availability of other governmental and non-governmental resources (including the private sector for HIV prevention); and*

7. *Other state and local determining factors*

In prioritizing the selected target populations, the each group decided to weight the ranking criteria in order to more exclusively prioritize the categories. The weighting values used by each group are listed as follows:

Significance	1
Value	2
Need	3
Risk	4
Effectiveness	5
Growth	6

- **Significance**: The level of infection and size of population segment (determined by epidemiology)
- **Value** of prevention:
  a. Intervention will likely make a lasting change in HIV risk behavior
  b. YPLL (years of potential life lost)
  c. Addresses emerging risk over established risk
- **Need** for prevention: To what degree is this group one that has been neglected or overlooked.
- **Risk** for HIV: Based on both documentation and personal experience - what is the risk of infection in this group?
- **Effectiveness**: Ability to access group members, receptiveness to prevention interventions and what is the likely success of outcome?, and
- **Growth**: The rate of infection growing/likely to grow in this population.

Once weighted and calculated, the final ranking matrices were created.

Small group work occurred throughout the planning process. It was an effective means of accomplishing some of the most challenging tasks facing the regional groups. By the later meetings, the need for small group break out sessions was not as critical for arriving at a consensus, but continued nevertheless. Throughout the monthly meetings the comments on the evaluation forms revealed that participants preferred working in small groups. There were opportunities at each meeting for small group work, although some members of the regional groups would have preferred this format be used more frequently. It was particularly helpful and effective in the two most arduous tasks, (1) identifying and rating target populations, and (2) reviewing and rating various prevention strategies for various populations. The small group work was most conducive to insuring the planning process was inclusive with the members selected for the regional groups.

Informational resources were readily available for the regional groups throughout the planning process, limited only by the absence of quantifiable data for selected issues or target populations. Where quantitative data was not available, the needs assessment team sought qualitative information through interviews with selected representatives of the community or from recognized local experts. Barriers included informational gaps and constraints with time or other resources that precluded obtaining all information sought.

Presentations on prevention and intervention occurred mid-way in the process.

Please refer to the target population by intervention and ranking criteria matrices in Attachment 5. They indicate which of the above mentioned criteria were considered in determining each 'high' priority ranking applied to a specific intervention.

CHAPTER 7: LINKAGES BETWEEN PRIMARY & SECONDARY PREVENTION and CARE

Linkages between primary and secondary prevention services are important to Nevada's overall approach to the AIDS epidemic. Primary prevention involves all efforts directed towards individuals who currently have not come in contact with HIV. Secondary prevention involves all efforts that prevent a more rapid progression to advanced HIV-related conditions for HIV positive persons; and efforts that interrupt further transmission of the AIDS virus by HIV positive persons to other individuals. Further, it is important to note that for high risk individuals secondary prevention also encompasses efforts which provide access to treatment and other support services related to co-factor conditions for transmission such as drug use/abuse, sexually transmitted diseases, homelessness, and mental illness.

Many of the agencies providing HIV prevention services in Nevada also provide and, therefore, receive funding for care and treatment services. Currently, most care and treatment services are funded by Ryan White Comprehensive AIDS Resources Emergency (CARE) Act -- Title I, II, and III funds. This funding structure provides the opportunities for agencies that provide primary prevention services (i.e., outreach and education to high-risk populations) to be aware of referral opportunities that are appropriate for, and unique to, the behaviors associated with HIV transmission.

All future Request for Proposal (RFP) processes will include, as part of the application, that agencies articulate how they intend to cooperate with other HIV service providers. Letters of commitment or Memoranda of Understanding (MOU) will be encouraged where appropriate.

In determining how to best enhance current coordination efforts the Regional CPGs began to discuss how to better engage people in HIV prevention, and HIV counseling, testing, and referral services (CTRS), and how these services could more strongly link to HIV care and treatment services. An additional issue that CPG members discussed was how to best evaluate the quality of links and the effectiveness of strategies for integrating prevention services into medical care and social service programs. CPG members articulated the following areas of emphasis:

- HIV prevalence is steadily increasing across all groups, and a large portion of those at risk for HIV infection appear to have availed themselves of Counseling Testing and Referral Services (CTRS);
- A significant proportion of HIV-infected persons are not in care, and therefore, not benefiting from services to either prolong the quantity and quality of life, or reduce transmission to others;
- Trends in HIV diagnoses by stage of disease indicate that a remarkably stable proportion of cases are diagnosed at the time AIDS is diagnosed;
- A new and complementary approach for HIV prevention is needed, focusing on the HIV-infected individual already in care;

- Delivering prevention messages must become an integral part of delivering care;
- Motivating individuals to use CTRS and reduce risk activities requires client trust and community and/or family support;
- Outreach programs targeting high-risk persons can be very effective at raising participation in CTRS, prevention and/or care services; and,
- CBOs must enhance and expand the HIV testing efforts for high-risk populations.

Regional CPG members reviewed examples of links and integration, barriers, and methods that have been used at the government, community and health care provider levels to address numerous barriers. From that review both regional groups agreed to the following actions to enhance and improve upon current actions that link community providers.

Organizational and Systems Issues

It is important to address organizational challenges from multiple perspectives, particularly community-based provider, academic health center, and state and city health planner-/administrator. Although these perspectives identify unique challenges and solutions, there are several common organizational issues and solutions. They are as follows:

1. Funding- Integration, Stabilization, Reimbursement Levels, and Targeting
   a. Agencies at the state level need to integrate care and prevention funds and grant activities.
   b. Agencies at the state level need to stabilize HIV prevention funding and extended grant periods.
   c. State entitlement and categorical programs need to sufficiently reimburse CTRS and HIV prevention personnel and services.
   d. Agencies at all levels need to increase services directed towards substance abusers and those experiencing mental illness.

2. Policy and Program Development- Comprehensiveness, Network Development, Protocols, and Competencies.
   a. Agencies at all levels need to develop service models for comprehensive, seamless CTRS, prevention, and care systems, by increasing existing provider capacity and establishing networks based on community health and social services needs.
   b. Enhanced networking to include both private and public providers and public and private payers (e.g., Ryan White, Medicaid, substance abuse block grants, private insured/managed care providers, etc.).
   c. Providers of care need to integrate prevention protocols in clinical and non-clinical settings, and establish provider training, technical assistance, and quality management procedures for such protocols.
   d. Providers need to integrate at the local level personnel and programs that address ethnic and cultural differences in the community.

3. Research, Evaluation, and Community Profiling- Access and Differential Outcomes

    a. State and local health departments need to develop HIV prevention care standards and protocols for purposes of integration into primary care and quality/performance assessment.

    b. State level agencies need to develop integrated service models for local use.

    c. State and local level agencies need to develop good reporting systems (e.g., HIV surveillance data) to identify risk pockets or subpopulations in small geographic areas.

    d. State and local level agencies need to develop evaluation methods and systems that create a profile of who is coming in late to treatment and the differential health related outcomes of certain communities and subpopulations.

    e. Local service providers need to apply evaluation to target CTRS activities, public awareness campaigns, and all other regional providers.

4. Commitment of Senior Administrators and Leaders- Collaboration and Administration

    a. Senior Administrators and Leaders need to show commitment and leadership in working across multiple agencies to integrate services. Senior Administrators and Leaders need to reduce administrative burdens at state and local levels.

    b. Local administrators and leaders need to reach out and create formal linkages with other agencies or services groups such as PTAs, human service providers, STD/TB clinics, family planning clinics, emergency rooms and acute care settings, substance abuse service providers, faith–based organizations and housing providers.

    c. Agency staff and senior directors at the state level need to develop stronger collaborative working relations with each other.

5. Outreach- Staff and Awareness

    a. Local providers need to promote that outreach staff create relationships with family, support providers, and other service providers (e.g., schools, human services, jails and prisons) to identify and bring individuals into care.

    b. Local providers need to use targeted public awareness campaigns.

    c. Local providers need to use peer outreach workers in the clinical and non-clinical settings.

Social Issues and Co-occurring Health Issues

There is a wide range of issues affecting the access and use of services among HIV-infected individuals with other co-occurring health and social conditions. Particular attention needs to be given to persons with substance abuse problems, minority women, homeless persons, and the incarcerated. There is an array of challenges in linking individuals from these groups to care and treatment.

1. Multiple challenges exist in identifying at-risk individuals in the community. Persons with active substance abuse, mental health, and/or housing problems may not have access to, or prioritize the importance of HIV counseling and testing in relation to other personal needs. Without treatment of the individual's problems, the individual may perceive unwillingness on the part of the medical community to provide care services.

2. The identification of at-risk individual needs to occur in the community. It is unlikely that most of these hard to reach individuals will come into the primary care settings for HIV testing alone. Thus, links need to be made with non-AIDS community providers and services that may be providing some type of services to all at-risk clients, such as detoxification and methadone maintenance sites, emergency rooms, family planning clinics, faith-based organizations, STD/TB clinics, and homeless shelters and/or any places where high-risk behavior is known to occur. Training of community providers and outreach activities in these settings is essential.

3. It is important to gain the initial and ongoing trust of at-risk individuals and HIV-infected persons in the care system. Peer outreach workers and peer counselors are an essential component of the care team that does this work. They are often the only ones who can go into a community to interact with high-risk clients, establish relations, and provide clients with ongoing peer support.

4. HIV health care providers must be integrated or linked with other essential service providers through meaningful business relations. This is particularly important in the delivery of HIV care, substance abuse services, mental health service, and housing and social services. Clients present with a multitude of health and social problems, along with HIV disease, that must be addressed in order for the client to remain effectively engaged in his/her HIV care. Thus, providers need to create (within their clinics or through networks with other providers) a wide continuum of physical and behavioral services that can address acute, short-term, and long-term treatment needs.

5. It is essential that providers assess risk activities at every client visit. Because of the discontinuous or intermittent nature of many of these problems, individual clients may need varying levels of risk reduction, substance abuse treatment, housing and other service throughout their course of treatment for HIV disease. Providers must be able to assess these needs and providers' referrals or access to appropriate services within the established provider network. These referrals must be done within the context of established relations with HIV providers, not simply to give the person a phone number or contact at an HIV facility.

6. Many management challenges exist. These include:

   a. Integration of funding streams in order to develop comprehensive service programs and linkages between prevention and clinical care services to meet client needs;
   b. Establishment of reasonable reimbursement levels and staff salaries for personnel delivering HIV prevention services;
   c. Establishment of an interdisciplinary team of physical and behavioral health providers that can communicate and share in patient care decisions; and,
   d. Creating flexibility in the provision of care (e.g., walk-in services, late night office-house, co-location of services and staff, transportation, childcare services or others) to assure that when the client is available he or she is provided care services.

CHAPTER 8: GOALS, OBJECTIVES & ACTIVITIES

The two respective regional groups in Nevada, (the CPG SoN and the NNPC), developed these goals over the course of a six-month planning process. Issues that surfaced consistently were noted and later developed into the final set of goals that were approved by both groups in August 2002. These goals fit within the context of the larger process of ongoing planning and implementation of HIV education and prevention activities within the state. Many goals are statements regarding the implementation of specific elements of the plan contained in other chapters.

Specific and more quantifiable objectives regarding the actual numbers of people to be served in certain target populations and the interventions to be provided will only be available after the process of agency solicitation and resource allocation has taken place. It is through the voluntary participation of community-based organizations that certain aspects of the plan will ultimately be implemented in full or not. The State hopes that this process of community planning will have created a sense of momentum and broaden the view of all the constituencies who provide, or who have the potential to provide, HIV prevention services in Nevada. It is also a keen reality that it is ultimately the availability of resources that builds and sustains the community's capacity to achieve the goals it sets.

It has been the intention of the State to lay out a plan that is both achievable and challenging and recognizes the need for both vision and practicality.

I. LONG RANGE GOALS OF THE HIV PREVENTION PLAN

A. <u>Implement HIV Prevention Plan/Maintain Community Planning Process</u>

1. People living in the state understand how HIV is transmitted, are able to assess individual or community risk for HIV infection, and have the skills and tools to protect themselves and others from HIV infection.

2. Specific action plans for each of the areas in the HIV Prevention Plan are developed, implemented, monitored and evaluated to include:
   a. strategies for *coordination and linkages* among major systems within the community;
   b. a *resource allocation process* that uses the priorities established by the CPG SoN and the NNPC for target populations and prevention strategies;
   c. an enhanced level of *technical assistance* that strengthens and builds the community capacity to provide effective HIV education and prevention programs and services.

3. An on-going community HIV prevention planning process is established and includes:
   a. an expanded membership base;
   b. a permanent structure and rules for governance;
   c. designated leadership with assigned roles and responsibilities.

4. Additional research and data collection is carried out regarding the needs of and effective prevention interventions for communities of color, people with disabilities, substance abusers, women, men who have sex with men, and people who are homeless. This research should be carried out in collaboration with representatives of the communities being studied and provides greater insight into the socio-economic factors in HIV transmission, as well as the effect of racial inequality on public health outcomes.

5. Community needs are evaluated regularly and new, emerging or un-addressed needs are addressed in a systematic way.

6. There is a long-range, statewide strategy, which includes coordination of prevention services and the evaluation of services.

B. Diversity and Cultural Sensitivity

1. The cultural context in which HIV/AIDS occurs is addressed in program design and implementation.

2. The framework of cultural literacy/cultural translation is incorporated in program design and implementation.

C. Community Cooperation and Coordination

1. Duplication of services is reduced, gaps are identified, and there is on-going coordination, cooperation and collaboration among all agencies and services in Nevada that provide HIV education and prevention which includes:
   a. broad dissemination of the HIV Prevention Plan within Nevada, to community-based organizations, health care providers, policy-makers, business leaders and the media;
   b. an annual (or biannual forum) open to all community organizations and the public on education and prevention strategies;
   c. a quarterly newsletter that solicits and provides updates on available resources, training and technical assistance and other issues or concern regarding HIV education and prevention.

2. HIV/AIDS education and prevention is institutionalized within new or existing organizations and offered in conjunction with other services, particularly those related to substance abuse or other health services.

D. Community Capacity-Building

1. Community agencies have more opportunities to increase effectiveness and build sustainable programs through training and technical assistance provided as part of the education and prevention services of the State that will include:
   a. a training session on Strategic Long Range Planning offered to all community agencies;
   b. a systematic way to provide technical assistance to community-based organizations involved in HIV prevention interventions has been established, evaluated and adapted to suit the needs of the agencies that choose to be involved;

c. non-traditional organizations are encouraged to develop and provide education and prevention strategies for their constituents.

2. Multi-year strategies are encouraged through funding, technical assistance and other support offered to agencies.

E. Effective Strategies

1. There is a balance between specific targeted interventions and wider community-level strategies.

2. Incentives are used effectively in educational programs for high-risk communities and communities of color.

3. Policy changes occur which make needle exchange possible as part of an overall plan to reduce injection drug use and stop the spread of HIV throughout the Nevada community.

II. FIRST YEAR IMPLEMENTATION ACTIVITIES

A. Implement HIV Prevention Plan/Maintain Community Planning Process

1. The Nevada State Health Division (NSHD) will support planning efforts to develop better community coordination with funders, health care providers, the criminal justice system, communities of faith and the educational system through the following:

   a. Distribute the plan or the executive summary or abridged version of the HIV Prevention Plan which includes key leaders and resource people in the identified systems as well as public policy makers, the media, business leaders, community organizations, school officials and others;
   b. Suggest opportunities for involvement in implementing the plan;
   c. Offer assistance in developing education and prevention activities for their constituencies;
   d. Design and implement an annual HIV Education and Prevention Forum for education and prevention service providers and community participants and include representatives of the identified systems;
   e. Request and arrange ongoing representation and involvement of funders, health care providers, representatives of the criminal justice system, leaders of communities of faith and people involved in the educational system in the HIV community planning process;
   f. Provide a statewide calendar of events and newsletter with information on successful program strategies and potential funding resources, which are available to representatives from the identified systems and to others.

2. Provide staff support and assistance for the continuation of the community HIV prevention planning process to enhance its membership, create a solid structure, select future leadership, establish a community needs assessment process and plan for future activities.

3. Work with the NSHD and local epidemiologists to create a plan to gain additional information on the needs of and effective prevention interventions for communities of color, women, substance abusers, men who have sex with men, and all other high-risk target populations.

4. Maintain communication and create opportunities for cooperation among Ryan White CARE Act planners and providers and coordinate with the related state and national agencies to monitor developments for long-range coordination.

B. Diversity And Cultural Sensitivity

1. Assist the NSHD to create multi-cultural advisory panels as part of the community prevention planning structure.

2. Develop staff skills and identify resources available for community and planning groups to learn more about incorporating cultural sensitivity and cultural translation into program design and implementation.

C. Community Cooperation and Coordination

1. Distribute HIV Prevention Plan as described above.

2. Plan and implement forum as described above.

3. Provide a quarterly newsletter as described above and in different elements of the plan.

4. Assist Regional CPGs to conduct outreach to community agencies who have participated in the 2002 community survey, particularly those related to substance abuse or other health services, and identify what would help them establish, maintain or expand HIV/AIDS education and prevention services in conjunction with ongoing program activities.

D. Community Capacity-Building

1. Assist the NSHD to study how multi-year intervention strategies can be encouraged through funding, technical assistance and other support offered to agencies.

E. Effective Strategies

1. Ask the External Evaluator to evaluate resource allocation both internal to the NSHD and external to contracts with community agencies to identify whether there is a balance between specific targeted interventions and wider community-level strategies.

2. Assist the NSHD to review and develop possible strategies for changing drug paraphernalia/ needle exchange policies in Nevada.

The Nevada State Health Division in coordination with the Clark County Health District and the Washoe County District Health Department will coordinate with or provide contract management for these six broad areas as follows:

1. *Facilities: Develop the needed facilities to serve all target populations.*
2. *Program Quality Improvement: To continue improving the quality of prevention services provided and the ability of programs to effectively serve all target populations.*
3. *Resource Development: To acquire the financial and other resources needed to effectively plan implement and evaluate HIV/AIDS Prevention programs in northern Nevada.*
4. *Research: Through rigorous methodologically and sound inquiry to provide the knowledge needed to plan, implement and evaluate HIV Prevention programs in northern Nevada.*
5. *Community Education: Design and implement a broad-based program that educates the public about an array of HIV prevention topics.*
6. *HIV/AIDS Prevention Policy: Design and implement a unified public policy agenda for HIV/Prevention and organize a grass-roots advocacy organization to advocate for its implementation.*

NORTHERN NEVADA COMMUNITY PLANNING GROUP GOALS & OBJECTIVES

Specific goals and objectives for each target population have been developed within the framework of these broader goals and are noted below.

POPULATION#1: INJECTING DRUG USERS

Intervention #1: Facilities for IDU

Goal: To decrease the practice of drug-using and needle-using risk behavior associated with HIV/STD infection.

Objective 1.1: By December 31, 2003, an experienced, well-qualified local agency will establish an IDU focused drop-in center for harm-reduction based outreach, education and planning.

Process Measure: By March 1, 2003, the state will issue a request for proposals.

Process Measure: By June 1, 2003, the approved agency will complete a comprehensive business plan and budget for the center, and develop harm-reduction training materials.

Objective 1.2: By December 31, 2004, the center will establish at least 1000 contacts with IDUs in a location where IDUs are known to congregate.

Process Measure: Staff will report quarterly numbers of IDU clients contacted

Objective 1.3: By December 31, 2004, the center will provide prevention case management to at least 200 consumers that self identify as IDUs.

Process Measure: Staff will report quarterly numbers of IDU receiving PCM.

Process Measure: Staff will report number and types of referrals made.

Outcome Measure: By the end of each calendar year the center will provide at least 2080 hours of drop-in counseling for IDUs.

Impact Measure: By December 31, 2004, the number of IDU entering treatment programs will increase by 10% over the calendar year 2003 baseline.

Objective 1.4: By December 31, 2004, the center will provide at least 75% of IDU contacts with referrals to substance abuse treatment, HIV medical care or other services for IDUs.

Process Measure: Staff will report quarterly numbers of referrals.

Impact Measure: By December 31, 2004, treatment centers will increase intake by10% from baseline over the calendar year 2003 baseline.

Objective 1.5: By January 1, 2004, the center will distribute bleach kits as needed during all open hours.

Process Measure: Staff will report number of bleach kits ordered and distributed quarterly.

Impact Measure: By January 1, 2004, bleach kits will be made available to all clients, thereby helping to reduce high-risk behavior.

Intervention #2: Policy Change for IDU
Goal: To legalize a needle exchange program in Nevada.

Objective 2.1: By May 31, 2003, each Community Planning Group or its designees will form the Nevada Needle Exchange Task Group (NETG), outline its short and long-term strategic objectives, and designate responsibilities.

Objective 2.2: By September 1, 2003, the NETG will create a detailed, time-phased plan to lobby the state legislature for the legalization of needle exchange, obtaining outside expertise if necessary.

Objective 2.3: By March 1, 2004, the Nevada Needle Exchange Task Group (NETG) will produce a coordinated statewide public relations campaign using high visibility people from academia, medicine, entertainment and other fields to promote the health and economic benefits of needle exchange.

Process Measure: By September 1, 2003, the NETG will publish a well-researched position paper that describes the costs of HIV and the health and economic advantages of needle exchange and effectively counters arguments against implementation of needle exchange; health officials and local residents will be asked to comment within 30 days.

Process Measure: By December 31, 2003, all state elected officials will receive copies of a well-researched position paper that describes the costs of HIV and the health and economic advantages of needle exchange and effectively counters arguments against implementation of needle exchange, and that responds to public comments on the first draft.

Intervention #3: Resource Development IDU
Goal: Obtain funds for research to develop model programs targeting IDU and other substance abusers.

Objective 3.1: By December 31, 2003, behavioral scientists/researchers will obtain at least $100,000 to fund a research study of model prevention programs targeting IDU.

Intervention #4: Program Quality Improvement for IDU
Goal: To improve HIV prevention program cultural competence with respect to drug users.

Objective 4.1: By June 1, 2003, Community Planning Groups in conjunction with local providers will establish standards and procedures for measuring cultural competence with respect to drug users using nationally recognized models and best practices in designing culturally competent interventions.

Objective 4.2: By January 31, 2004, 100% of state or federally funded HIV/AIDS Prevention programs operating in Nevada will use standards and procedures for measuring their cultural appropriateness/competency (including "drug competency") as part of their standard operating procedures.

Impact Measure: By August 31, 2004, 25% of state or federally funded HIV/AIDS Prevention programs operating in Nevada will show an increase over baseline in the program's cultural competency (including "drug competency").

Impact Measure: By August 31, 2004, 15% of clients served by state or federally funded HIV/AIDS prevention programs operating in Nevada will measure an increase over baseline in client satisfaction with program cultural competency (including "drug competency").

POPULATION #2: MEN WHO HAVE SEX WITH MEN

Intervention #1: Facilities for MSM
Goal: To create an urban gay counseling center to provide counseling, HIV education and risk reduction, prevention case management and related services for gay men and women.

Objective 5.1: By June 2003, an experienced community-based organization will produce a comprehensive business plan and funding proposal for the center.

Process Measure: By March 1, 2003, the state will issue a request for proposals.

Objective 5.2: By December 2003, an experienced community-based organization will secure funding and begin operations of center.

Process Measure: By September 2003, the approved community-based organization will begin implementing its business plan to secure funding, office space, staff, and material resources for the center.

Objective 5.3: By June 2004, the center will make at least 1,000 contacts with men and women who self-identify as gay.

Process Measure: By March 2004, the center will provide quarterly reports on numbers and demographics of contacts made, and types of services made available to contacts.

Impact Measure: By December 31, 2004, clients will report improved physical, mental, and emotional well being as a result of the services provided at the center.

Intervention #2: Research the MSM population
Goal: Create and implement a social marketing campaign specifically designed to educate MSM who do not identify as gay about HIV risk and risk reduction practices.

Objective 6.1: By January 2003, funded agencies in Nevada will collaborate to review existing research on the population of MSM who don't identify as gay, including the following

populations: transgender, incarcerated, Latino, African American, Native American, Asian, and sex workers (male and female), and identify effective programs for educating this population about HIV risk and risk reduction practices.

Objective 6.2: By March 2003, community planning groups will finalize a 1-2 year, detailed social marketing plan and budget with the assistance of outside expertise, if necessary

Process Measure: Beginning January 2003, community planning groups will meet twice a month to create the plan and budget.

Objective 6.3: By May 2003, regional community planning groups will secure funding and begin implementing the social marketing campaign.

Outcome Measure: By November 2003, media campaigns will reach each targeted population, or at least 700 MSM, with culture-specific messages about HIV risk reduction practices.

Impact Measures: By May 2004, rates of infection among targeted groups will decline.

POPULATION #3: HETEROSEXUAL MEN, WOMEN AND YOUTH

Intervention #1: Public Education for Heterosexual Men, Women and Youth

Goal: To design and implement public education programs on HIV risk and risk reduction with special emphasis on youth.

Objective 7.1: By July 1, 2003, a qualified organization will operate a youth-run low watt radio station.

Process Measure: By March 1, 2003, a qualified organization will be selected to create a radio station and incorporate youth-directed programming into its daily program.

Impact Measure: By January 1, 2004, a survey of the general public will be used to document behavior changes as a result of the radio spots.

Goal: To engage local universities to answer the question "When should HIV prevention begin for youth?"

Objective 8.1: By December 31, 2004, the Washoe County District Health Department and Clark County Health District (or outside consultant) will review existing research on the youth HIV education with special emphasis on the appropriate developmental age to begin HIV education.

Objective 8.2: With the results of Objective 8.1, community planning groups will develop a detailed plan to lobby elected officials and inform the general public of its findings.

Goal: By the end of the next legislative session, legislators will mandate a standardized HIV curriculum in 17 counties approved by the State AIDS Task Force and the State Board of Health.

Intervention #2: Public Awareness for Heterosexual Men, Women and Youth
Goal: To increase awareness of and knowledge about HIV/AIDS, with special emphasis on issues pertaining to women and youth, by urging elected officials to support and fund public awareness campaigns.

Objective 9.1: By December 31, 2004, the State AIDS Task Force (to include PWAs and a prevention specialist) will make at least 75 individual contacts per year with Nevada elected officials advocating funding and support programs to increase public awareness of and knowledge about HIV/AIDS, with special emphasis on issues pertaining to women and youth.

Process Measure: Beginning January 1, 2003, the State AIDS Task Force will allocate responsibilities, report individual contacts, and deliver progress reports quarterly.

Outcome Measure: Issue presented to state legislature.

Outcome Measure: Funding allocated for public awareness campaigns targeting youth and women.

Impact Measure: Increased public knowledge leads to decreased HIV transmission rates among women and youth.

POPULATION #4: PARTNERS of IDU/ HIGH-RISK FEMALES

Intervention #1: Resource Development for Partners of IDU/High-Risk Females

Goal: To increase program resources and training for female self-empowerment with emphasis on increase to IDU services.

Objective 10.1: By December 31, 2003, 100% of substance abuse treatment centers will offer support groups for women.

Process Measure: Beginning March 1, 2003, providers will report quarterly on steps achieved to implement support groups and resources needed.

Outcome Measure: Target population will attend support group meetings regularly.

Impact Measure: 20% of females will report self-empowerment using indicators such as: leaving abusive relationships, getting a better job, etc.

ALL POPULATIONS

Intervention #1: Facilities for HIV/AIDS

Goal: Establish a multipurpose building for HIV/AIDS-related services, which promotes collaboration of agencies and minimizes capital expenditures.
Objective 11.1: By December 31, 2004, a collaboration of currently funded CBOs will develop a specific plan for a multipurpose HIV/AIDS-related services building which identifies all current and projected program needs, space requirements for housing those programs and current and projected funds to implement the building.

Objective 11.2: By December 31, 2004, the Nevada State Health Division (with NNPC, CPG SoN and CDC) will identify potential revenue sources for funding the building.

Objective 11.3: By December 31, 2005, a multipurpose HIV services building will be operating in Nevada.

> Impact Measure: 50-75% of clients agree this is more convenient and thus they are accessing more services.

Intervention #2: Program Quality Improvement
Goal: To increase HIV prevention program quality with special emphasis on improving program cultural competence.

Objective 12.1: By July 31, 2003, 100% of state or federally funded HIV/AIDS prevention programs will incorporate standards of care and best practices into daily operations.

> Process Measure: Beginning January 1, 2003, state or federally funded HIV/AIDS prevention case management programs operating in Nevada will develop standards of care, operational policies and procedures, and local models based on nationally recognized best practices.
>
> Impact Measure: By December 31, 2003, 100% of programs in compliance with CDC guidelines for prevention case management will demonstrate increased quality of service delivery.

Objective 12.2: By December 31, 2003, 100% of state and federally funded HIV prevention programs in Nevada will measure client satisfaction as part of their program evaluation and incorporate results into program planning.

> Impact Measure: Client satisfaction and retention will increase by 25% in 2004.

Objective 12.3: By December 31, 2003, 100% of state or federally funded HIV/HIV prevention case management programs operating in Nevada will train staff and/or volunteers in program implementation, monitoring, and evaluation.

Intervention #3: Resource Development

Goal: To implement programs to increase HIV prevention funding to serve all target populations.

Objective 13.1: By July 31, 2003, the Nevada State Health Division will produce a concise position paper explaining the HIV prevention system, the role of state funding in supporting prevention programming, the need for more prevention funding, and the process by which citizens can advocate for more prevention funding.

Objective 13.2: By December 31, 2003, NNPC/CPG SoN members and currently funded agency members will make at least 150 contacts with elected state officials advocating for more prevention funding, including continuation of current programs at or above current funding.

Process Measure: Beginning January 1, 2003, the community planning groups will allocate responsibilities, report individual contacts, and deliver progress reports quarterly.

Outcome Measure: Issue presented to state legislature resulting in sponsoring bills and policy changes.

Outcome Measure: Funding allocated for public awareness campaigns targeting youth and women.

Impact Measure: Increased public knowledge leads to decreased HIV transmission rates.

Objective 13.3: By December 31, 2003, NNPC/CPG SoN members will create an HIV/AIDS prevention state license plate approved by state officials.

Process Measure: Community planning group members will meet quarterly beginning in March 2003 to determine legal requirements and a plan of action to create the new license plate.

Intervention #4: HIV/AIDS Prevention Policy

Goal: To organize an HIV Advocacy Network that can recruit, train, and activate grassroots volunteers to advocate for an HIV prevention policy agenda.

Objective 14.1: By December 31, 2003, a qualified community-based organization will recruit and train at least five volunteer trainers who will train community volunteers in advocacy skills.

Process Measure: CBOs will report quarterly on selection of candidates and training program.

Outcome Measure: By December 31, 2004, the volunteers will train others during periodic training sessions to be established by the Network.

Objective 14.2: By December 31, 2004, the NNPC, the State Health Division, the Washoe County District Health Department and the Clark County Health District will agree on a unified HIV prevention policy agenda, including specific positions on prevention funding, youth education strategies and harm reduction policies including needle exchange.

Process Measure: The CPGs and state health agency officials will meet monthly to prioritize policy goals and allocate responsibilities within the group for researching and presenting findings on various policy issues.

Impact Measure: Funding and legislative support for actions taken by the community planning groups and state health agencies will increase each year beginning in 2004.

SOUTHERN NEVADA COMMUNITY PLANNING GROUP OVERARCHING GOALS

OVERARCHING GOALS:

- 100% of prevention-funded agencies will collaborate and support the prevention coalition and show documentation as such.

- Increase access to confidential testing, particularly in communities of color and communities with high HIV incidence or prevalence and/or high rates of other STDs.

- By December 31, 2003, Community Planning Groups in conjunction with the State AIDS Task Force, or their designees, will form a committee to address school-based curriculums addressing HIV/STDs. This committee will also look at policies and outline short and long-term strategies, goals/objectives that will be given to the State Board of Education.

- By December 31, 2003, Community Planning Groups in conjunction with the State AIDS Task Force, or their designees, will form the Nevada Harm Reduction Task Group (NHRTG). This task group will look at policies and outline short and long-term strategies and objectives, and designate responsibilities with the Needle Recovery Program.

- By December 31, 2003, increase collaboration and working relationships between HIV and STD providers in the private and non-private sectors and show documentation of such.

- By January 1, 2003, improve collaboration with Family Planning and STD clinics, private and non-private sectors, to assure HIV/ STD testing and education is increased.

- By December 31, 2003, CPG-SoN will assess the feasibility of a single point of access for supplies, clearinghouse, hotline and website not only for HIV+ individuals but the HIV/STD/TB prevention community.

- By December 31, 2004, secure funding and organize the infrastructure of a single point access warehouse. The warehouse will be completely established and functioning by end of 2005.

- By December 31, 2005, provide, in conjunction with State Health Division and Washoe County District Health Department, two statewide prevention conferences that build knowledge and capacity of the HIV/STD/TB community.

- By December 31, 2005, provide six training opportunities and education programs regarding individual level interventions (ILI) and the other intervention strategies, Program Evaluation and reporting information to increase the knowledge and the capacity of service providers.

- By December 31, 2005, all prevention-funded agencies will include an evidence-based component to the HIV programs that addresses the risk for HIV, alcohol and other drugs (e.g., crack cocaine, crystal methamphetamine).

- Through capacity building and technical assistance, increase the proportion of prevention providers who successfully provide effective evidence-based programs and culturally competent HIV prevention interventions for all targeted populations.

POPULATION #1: HIV+

Goal: Through primary and secondary prevention and education increase the knowledge and behaviors that reduce the risk of spreading HIV and STDs among HIV+ individuals and their partners.

INDIVIDUAL – LEVEL INTERVENTIONS:
Health Education/Risk Reduction: *(Ranked High)*

By December 31, 2003, increase performance ratings of HIV/STD counseling staff by auditing staff abilities and understanding of this intervention and other interventions to reach the HIV+ community.

GROUP – LEVEL INTERVENTIONS:
Speakers Bureau: *(Ranked Medium)*
Group Presentation: *(Ranked Medium)*
Multi-Sessions Groups: *(Ranked High)*
Peer education: *(Ranked High)*

- 100% of HIV/AIDS/STD educational programs will collaborate with HIV+ individuals who are trained and certified in HIV/AIDS/STD education and presentations. Improving the link between HIV+ individuals and HIV/AIDS/STD education.
- 100% of prevention-funded agencies that target this population will provide outlines and curriculums to show a skill-based approach.

OUTREACH:
Peer: *(Ranked High)*
Paraprofessional: *(Ranked Medium)*

- 100% of prevention-funded agencies that target this population will provide outlines and curriculums to show a peer or paraprofessional approach.
- 100% of prevention-funded agencies that target the HIV+ community will collaborate with the already existing outreach programs.
- 100% of prevention-funded agencies that target the HIV+ community with this intervention will evaluate outreach staff twice a year and provide documentation.

Partner Counseling Referral Services: *(Ranked High)*

- 100% of partners of HIV+ individuals will receive counseling to assure increased safer sex practices and, if infected, early medical intervention and referrals.
- The number of HIV+ individuals who have partners notified will increase by 25% by end of 2005.

- Improve surveillance approach to notifying sex and needle-sharing partners of HIV infected persons of their possible exposure to HIV/STDs.

HEALTH EDUCATION PUBLIC INFORMATION:
Hotline: *(Ranked Medium)*
Clearing House: *(Ranked High)*

- 100% of prevention-funded agencies that target the HIV+ community with this intervention will provide outlines and curriculums that address education and knowledge.

COMMUNITY LEVEL INTERVENTIONS:
Community Mobilization: *(Ranked High)*
Social marketing Campaigns: *(Ranked High)*
Structural Intervention: *(Ranked Medium)*

- Implement, evaluate and document strategies addressing real and perceived barriers to testing -- such as fears concerning being infected/testing positive, stigmatization, criminalization, parental/guardian notification, partner notification, violence, risk of deportation and confidentiality (including the impact of implementing HIV named reporting), concerns about cultural and linguistic barriers – at individual, community, societal and structural levels.

CTRPN: (Counseling, Testing, Referral, Partner Notification)

- 100% of HIV+ individuals who return for their results will be referred to early intervention clinic where they will receive medical intervention, advanced knowledge on current health status, HIV/ STDs, safer sex information and referrals and post disclosure issues.
- 100% of HIV+ individuals who access testing sites and collaborating agencies will be evaluated in concatenation with secondary prevention services to assure continuity of care and early intervention.
- 100% of HIV+ individuals who return for test results or contacted through collaborating agencies will be assessed for mental health, drug and alcohol problems and referred appropriately.
- 100% of prevention-funded agencies that target the HIV+ community will show documentation and collaboration for all related referrals.
- Improve screening diagnosis and treatment of HIV/STDs, including hepatitis and TB, among persons with HIV infection, particularly those in collaborating agencies.

PROGRAMS AND EVALUATION:
- 100% of prevention-funded agencies that target the HIV+ community will collaborate with the HIV+ community and conduct a minimum of two focus groups a year to assure quality and necessity of prevention-funded agencies programs.
- Increase the availability of free or low-cost HIV testing at both clinical and non-clinical sites in high sero-prevalence areas, including urgent care centers and emergency rooms, community-based organizations, STD clinics, substance abuse treatment centers and Harm Reduction Task Groups, street outreach programs, faith-based service centers, welfare offices and family planning clinics.

- By January 1, 2004, based on audit outcomes, increase trainings which address knowledge and skills of HIV/STD counseling staff on this intervention and others to help reach and educate the HIV+ community.

POPULATION #2: MSM

Goal: Through prevention and education increase the knowledge and behaviors that reduce the risk of spreading HIV and STDs among MSM in connection to GLBT community.

INDIVIDUAL – LEVEL INTERVENTIONS:
Health Education/Risk Reduction: *(Ranked Medium)*

- By December 31, 2003, increase performance ratings of HIV/STD counseling staff by auditing staff abilities and understanding of this intervention and other interventions to reach the MSM community.
- By December 31, 2004, based on audit outcomes, increase the knowledge and skills of HIV/STD counseling staff on this intervention and others to help reach and educate the MSM community.

GROUP – LEVEL INTERVENTIONS:
Multi-session groups: *(Ranked High)*
Peer education: *(Ranked High)*

- 100% of prevention-funded agencies that target the MSM community will provide an outline and curriculums to show multi- session, peer education and skill based approach.

OUTREACH:
Peer: *(Ranked Medium)*

- 100% of prevention-funded agencies that target the MSM community will collaborate with the already existing outreach programs.
- 100% of prevention-funded agencies that target the MSM will provide outlines and curriculums to show a peer based approach.
- 100% of prevention-funded agencies that target the MSM community with this intervention will evaluate outreach staff twice a year and provide documentation.

Partner Counseling Referral Services: *(Ranked High)*

- 100% of HIV+ partners of MSM individuals will receive counseling to assure increased safer sex practices and, if infected, early medical intervention and referrals.
- Improve surveillance approach to notify sex and needle-sharing partners of MSM infected persons of their possible exposure to HIV/STDs.

HEALTH EDUCATION PUBLIC INFORMATION:
Electronic Media: *(Ranked Medium)*

Print Media: *(Ranked High)*
Hotline: *(Ranked Medium)*
Clearinghouse: *(Ranked High)*

- Prevention funded agencies who target the MSM community will collaborate with the Prevention Information Specialist to develop and distribute an agency-wide newsletter, plan and implement a minimum of two regional or county-specific educational, public awareness or media projects, events or campaigns per year to help reduce stigma, discrimination and domestic violence surrounding MSM community.

COMMUNITY LEVEL INTERVENTIONS:
Community Mobilization: *(Ranked High)*
Social marketing Campaigns: *(Ranked High)*
Community wide events: *(Ranked High)*
Policy Interventions: *(Ranked Medium)*
Structural Intervention: *(Ranked High)*

- Implement, evaluate and document strategies addressing real and perceived barriers to testing – such as fears concerning being infected/testing positive, stigmatization, criminalization, parental/guardian notification, partner notification, violence, risk of deportation and confidentiality (including the impact of implementing HIV named reporting), concerns about cultural and linguistic barriers – at individual, community, societal and structural levels.
- 100% of prevention-funded agencies that target this population will collaborate with the MSM community and hold a minimum of two focus groups a year to assure quality and necessity of prevention-funded agencies programs.

CTRPN: (Counseling, Testing, Referral, Partner Notification)

- 100% of MSM individuals who return for test results or contacted through collaborating agencies will be assessed for mental health, drug and alcohol problems and referred appropriately.
- 100% of prevention-funded agencies that target the MSM community will show documentation of referrals and follow up made for mental health, drug and alcohol related issues.
- Improve screening diagnosis and treatment of HIV and concomitant STDs including hepatitis and TB among MSM, particularly those in collaborating agencies.
- Improve collaboration with Family Planning and STD clinics, private and non-private sector, to assure HIV/STD testing and education is increased for the MSM population.
- Ensure that MSM diagnosed with STDs receive counseling and are offered testing for HIV.

PROGRAMS AND EVALUATION:

- Improve screening, diagnosis and treatment of STDs among MSM, including those within collaborating agencies systems.
- Implement and evaluate evidence-based HIV prevention programs for male-to-female transgender/gender variant male persons who have sex with men, particularly those who engage in sex for money, drugs or survival.

- Increase the availability of free or low-cost HIV testing at both clinical and non-clinical sites in high sero-prevalence areas, including urgent care centers and emergency rooms, community-based organizations, STD clinics, substance abuse treatment centers and Harm Reduction Task Groups, street outreach programs, faith-based service centers, welfare offices and family planning clinics.

POPULATION #3: IDU

Goal 1: Through prevention and harm reduction education, increase the knowledge and behaviors that reduce drug abuse and the risk of spreading HIV and STDs among IDUs and their partners.

Goal 2: Increase comprehensive services for IDUs, including HIV/STD testing (including hepatitis), substance abuse treatment, and methadone maintenance and harm reduction programs to promote non-sharing of injection equipment and use of sterile injection equipment.

INDIVIDUAL – LEVEL INTERVENTIONS:
Health Education / Risk Reduction: *(Ranked High)*

- By Dec 31, 2003, increase performance ratings of HIV/STD counseling staff by auditing staff abilities and understanding of this intervention and other interventions to reach the IDU community.
- By Dec 31, 2004, based on audit outcomes, increase the knowledge and skills of HIV/STD counseling staff on this intervention and others to help reach and educate the IDU community.

GROUP – LEVEL INTERVENTIONS:
Group Presentation: *(Ranked Medium)*

- 100% of prevention-funded agencies that target the IDU community will provide outlines and curriculums to show a skill based and harm reduction approach.

OUTREACH:
Paraprofessional: *(Ranked High)*

- 100% of prevention-funded agencies that target the IDU community will collaborate with the already existing outreach programs.
- 100% of prevention-funded agencies that target the IDU will provide outlines and curriculums to show a paraprofessional based approach.
- 100% of prevention-funded agencies that target the IDU community with this intervention will evaluate outreach staff twice a year and provide documentation.

Partner Counseling Referral Services: *(Ranked High)*

- 100% of partners of HIV+ IDU will receive counseling to assure increased safer sex practices and increase harm reduction regarding needle sharing, if appropriate.

- Improve surveillance approach for notifying sex and needle-sharing partners of HIV+ infected persons of their possible exposure to HIV/STDs.

HEALTH EDUCATION PUBLIC INFORMATION:
Electronic Media: *(Ranked High)*
Print Media: *(Ranked High)*

- Prevention-funded agencies that target the IDU community will collaborate with the Prevention Information Specialist to develop and distribute an agency-wide newsletter, plan and implement a minimum of two regional or county-specific educational, public awareness or media projects, events or campaigns per year to help reduce stigma, discrimination and domestic violence surrounding IDU community.

COMMUNITY LEVEL INTERVENTIONS:
***Policy Interventions:** *(Ranked Low)*
***Structural Intervention:** *(Ranked Low)*

- Conduct research and disseminate results to the NHRTG and The State AIDS Task Force on the effectiveness of a needle recovery program and other mechanisms for providing sterile syringes to active injectors (e.g., changes in prescription and possession laws).
- Implement, evaluate and document strategies addressing real and perceived barriers to testing – such as fears concerning being infected/testing positive, stigmatization, criminalization, parental/guardian notification, partner notification, violence, risk of deportation and confidentiality and concerns about cultural and linguistic barriers – at individual, community, societal and structural levels.

CTRPN: (Counseling, Testing, Referral, Partner Notification)

- 100% of IDU individuals who return for test results or contacted through collaborating agencies will be assessed for mental health, drug and alcohol problems and referred appropriately.
- 100% of prevention-funded agencies which target the IDU community will show documentation of referrals and follow up made for mental health and drug and alcohol related issues.
- Improve screening diagnosis and treatment of HIV and concomitant STDs including hepatitis and TB among IDUs, particularly in collaborating agencies.
- Improve collaboration with Family Planning and STD clinics; private and non-private sectors, to assure that HIV/STD testing and education is increased to the IDU population.
- Ensure that IDU individuals diagnosed with STDs receive counseling and are offered testing for HIV.

***CPG SoN footnoted these ranking areas as shown; they were ranked low due to the infrastructure of this community at this time. However, we understand the importance of this issue and realize it merits further consideration.**

PROGRAMS AND EVALUATION:

- Implement and evaluate culturally competent HIV prevention interventions targeting IDUs, particularly IDUs of color and those within collaborating agencies.
- Provide collaborating agencies that work with the IDU community with health education/risk reduction (HE/RR) and linkages to HIV, STD and substance abuse prevention and treatment programs, mental health programs and other community-based services.
- 100% of prevention-funded agencies that target the IDU community will show documentation and collaboration for all related referrals.
- Improve screening, diagnosis and treatment of STDs among IDUs, including those within collaborating agencies systems.
- Increase the availability of free or low-cost HIV testing at both clinical and non-clinical sites in high sero-prevalence areas, including urgent care centers and emergency rooms, community-based organizations, STD clinics, substance abuse treatment centers and Harm Reduction Task Groups, street outreach programs, faith-based service centers, welfare offices and family planning clinics.
- By Dec 31, 2003, conduct a second survey which substitutes existing documentation encouraging a dirty needle cleanup program keeping our police and community members safe in Clark County.

POPULATION #4: HETEROSEXUALS AND PARTNERS

Goal: Through prevention and education, increase the knowledge and behaviors that reduce the risk of spreading HIV and STDs among heterosexuals and their partners with an emphasis on women and communities of color.

INDIVIDUAL – LEVEL INTERVENTIONS:
Health Education / Risk Reduction: *(Ranked Medium)*

- By December 31, 2003, increase performance ratings of HIV/STD counseling staff by auditing staff abilities and understanding of this intervention and other interventions to reach heterosexuals and partners with an emphasis on women and communities of color.
- By December 31, 2004, based on audit outcomes increase the knowledge and skills of HIV/STD counseling staff on this intervention and others to help reach and educate heterosexuals and partners.
- By December 31, 2003, through individual level interventions (ILI), document and create a referral system that addresses the needs of heterosexuals and partners, specifically women and communities of color.

GROUP – LEVEL INTERVENTIONS:
Group Presentation: *(Ranked Medium)*
Multi – session groups: *(Ranked High)*
Peer Education: group, multi – sessions: *(Ranked High)*

- 100% of prevention-funded agencies that target the heterosexual community and use this intervention will use multi-session groups with peer and non-peer models involving a wide range of skills to enhance knowledge around safer sex practices.
- 100% of prevention-funded agencies that target the heterosexual community will provide outline and curriculums to show a skill-based approach.

OUTREACH:
Peer: *(Ranked Medium)*

- 100% of prevention-funded agencies that target the heterosexual community will collaborate with already existing outreach programs or the Health District Office of AIDS.
- 100% of prevention-funded agencies that target the heterosexual community will collaborate with the already existing outreach programs.
- 100% of prevention-funded agencies that target the heterosexual community will provide outlines and curriculums to show a peer-based approach.
- 100% of prevention-funded agencies that target the heterosexual community with this intervention will evaluate outreach staff twice a year and provide documentation.

Partner Counseling Referral Services: *(Ranked Medium)*

- 100% of Heterosexuals and Partners who test will receive counseling to assure increased safer sex practices and, if infected, early medical intervention and referrals.

HEALTH EDUCATION PUBLIC INFORMATION:
Clearinghouse: *(Ranked High)*
Presentation / Lectures: *(Ranked Medium)*

- 100% of prevention-funded agencies which target the heterosexual community with an emphasis on women and communities of color, will provide outlines and curriculums that educate and increase knowledge around HIV/AIDS/STDs and hepatitis

COMMUNITY LEVEL INTERVENTIONS:
Community Mobilization: *(Ranked Medium)*
Social marketing Campaigns: *(Ranked Medium)*
Community – wide Events: *(Ranked Medium)*
Policy Interventions: *(Ranked High)*
Structural Intervention: *(Ranked Medium)*

- Implement, evaluate and document strategies addressing real and perceived barriers to testing – such as fears concerning being infected/testing positive, stigmatization, criminalization, parental/guardian notification, partner notification, violence, risk of deportation and confidentiality (including the impact of implementing HIV named reporting), concerns about cultural and linguistic barriers – at individual, community, societal and structural levels.

CTRPN: (Counseling, Testing, Referral, Partner Notification)

- 100% of heterosexuals, specifically women and communities of color, who return for test results who state they have issues with mental health, drug and or alcohol problems will be referred appropriately.
- 100% of prevention-funded agencies that target the heterosexual community will show documentation of referrals and follow up made for mental health and drug and alcohol related issues.
- Improve screening diagnosis and treatment of HIV and concomitant STDs, among heterosexuals, particularly those in collaborating agencies.
- Improve collaboration with Family Planning and STD clinics, private and non-private sector, to assure that HIV/STDs testing and education is increased to the heterosexual population.
- Improve and document that all heterosexuals and partners diagnosed with STDs receive counseling and are offered HIV testing.

PROGRAMS AND EVALUATION:

- Implement and evaluate evidence-based behavioral HIV prevention programs which strengthen the capacity of women, especially women of color and those engaged in sex work, to make and carry out decisions to reduce their sexual risk and increase their protective behaviors (e.g., correct, consistent and appropriate condom use, reductions in higher-risk sexual practices, early diagnosis and treatment of STDs).
- Increase the proportion of prevention providers who successfully provide evidence-based effective, culturally competent HIV prevention interventions for sexually active women and heterosexual men.
- Implement and evaluate evidence-based behavioral HIV prevention interventions in STD clinics, primary care and family planning settings, especially in communities of color.
- Implement and evaluate evidence-based behavioral HIV prevention programs for heterosexual men, especially men of color and those found in collaborating agencies systems.
- Increase the availability of free or low-cost HIV testing at both clinical and non-clinical sites in high sero-prevalence areas, including urgent care centers and emergency rooms, community-based organizations, STD clinics, substance abuse treatment centers and Harm Reduction Task Groups, street outreach programs, faith-based service centers, welfare offices and family planning clinics.

POPULATION #5: GENERAL POPULATION

Goal: Through prevention and education, increase the knowledge and behaviors that reduce the risk of spreading HIV and STDs among the general population with an emphasis on youth.

INDIVIDUAL – LEVEL INTERVENTIONS:
Health Education / Risk Reduction: *(Ranked Medium)*

- By December 31, 2003, increase performance ratings of HIV/STD counseling staff by auditing staff abilities and understanding of this intervention and other interventions to reach general population with an emphasis on youth.

- By December 31, 2004, based on audit outcomes, increase the knowledge and skills of HIV/STD counseling staff on this intervention and others to help reach and educate general population with an emphasis on youth

GROUP – LEVEL INTERVENTIONS:
Group Presentation: *(Ranked Medium)*
Multi – session groups: *(Ranked High)*
Peer Education: group, multi – sessions: *(Ranked Medium)*

- 100% of prevention-funded agencies that target the general population with an emphasis on youth will provide outline and curriculums to show a skill-based approach.
- 100% of prevention-funded agencies that target the general population and use this intervention will use multi-session groups with peer and non-peer models involving a wide range of skills to enhance knowledge around safer sex practices.

OUTREACH:
Peer: *(Ranked Medium)*
Paraprofessional: *(Ranked High)*

- 100% of prevention-funded agencies that target the general population with an emphasis on youth will collaborate with the already existing outreach programs or the Clark County Office of AIDS.
- 100% of prevention-funded agencies that target the general population will provide outlines and curriculums to show a paraprofessional based approach.
- 100% of prevention-funded agencies that target the general population with this intervention will evaluate outreach staff twice a year and provide documentation.

HEALTH EDUCATION PUBLIC INFORMATION:
Hotline: *(Ranked Medium)*
Clearinghouse: *(Ranked High)*
Presentation / Lectures: *(Ranked Medium)*

- Prevention-funded agencies that target the general population with an emphasis on youth will collaborate with the Public Information Specialist to develop and distribute an agency-wide newsletter, plan and implement a minimum of two regional or county-specific educational, public awareness or media projects, events or campaigns per year to help reduce stigma, discrimination and domestic violence surrounding general population with an emphasis on youth.

COMMUNITY LEVEL INTERVENTIONS:
Community wide events: *(Ranked High)*

- Implement, evaluate and document strategies addressing real and perceived barriers to testing – such as fears concerning being infected/testing positive, stigmatization, criminalization,

parental/guardian notification, partner notification, violence, risk of deportation and confidentiality (including the impact of implementing HIV named reporting), concerns about cultural and linguistic barriers – at individual, community, societal and structural levels.

CTRPN: (Counseling, Testing, Referral, Partner Notification)

- 100% of general population with an emphasis on youth who return for test results, who state they have issues with mental health, drug and or alcohol problems, will be referred appropriately.
- 100% of prevention-funded agencies that target the general population with an emphasis on youth will show documentation of referrals and follow up made for mental health and drug and alcohol related issues.
- Improve screening diagnosis and treatment of HIV and concomitant STDs among youth and the general population.
- Improve collaboration with Family Planning and STD clinics, private and non-private sector, to assure that HIV/STD testing and education is increased to the general population, particularly in those clinics that target youth.
- Improve and document that all general population and youth diagnosed with an STD receive counseling and are offered HIV testing.

PROGRAMS AND EVALUATION:

- Research, develop, implement and evaluate programs that help reduce adolescents' sexual risk-taking connected with all substance use.
- Integrate HIV/STD prevention into unplanned pregnancy prevention programs for young people.
- Ensure that persons with other STDs receive counseling and voluntary testing for HIV.
- Implement and evaluate population-specific, culturally and linguistically competent models of integrating STD and HIV counseling and testing.
- Increase the availability of free or low-cost HIV testing at both clinical and non-clinical sites in high sero-prevalence areas, including urgent care centers and emergency rooms, community-based organizations, STD clinics, substance abuse treatment centers and Harm Reduction Task Groups, street outreach programs, faith-based service centers, welfare offices and family planning clinics.
- Help agencies in assisting state and local correctional facilities, including juvenile detention facilities and boot camps, as well as probation and parole systems, to provide HIV/STD educational services, HIV/STD counseling and voluntary testing.
- Increase the proportion of sexually active youth and young adults who are routinely offered HIV/STD counseling and voluntary testing.

CHAPTER 9: A TECHNICAL ASSISTANCE & CAPACITY BUILDING PLAN

I. NEED FOR TECHNICAL ASSISTANCE AND CAPACITY BUILDING

The regional planning groups in Nevada (CPG SoN and NNPC) represent agencies that provide HIV/AIDS education and prevention services and agencies serving at-risk HIV populations who have shared interest in improving the effectiveness of HIV education and prevention programs. To this end, every organization receiving prevention funds in Nevada will be encouraged, and assisted to develop a long-range, strategic plan for that organization and to identify the role of HIV prevention services within the organization's long-range plans.

Although each regional group makes funds available to community agencies to carry out HIV/AIDS education and prevention activities, it is important to recognize that these funds do not represent the entire extent of all funds available to community agencies for these purposes. Given the limitations of public funding, in general, community agencies need to acquire knowledge and skills to create effective programs and build and maintain organizations that are not solely dependent on one funding source. The agencies and the programs they operate must be financially prepared to ensure their own long-term survival.

Thus, agencies are advised of the critical need to develop plans that enable them to obtain funds for HIV/AIDS education and prevention services from sources beyond solely the funds from the NNPC and CPG SoN. Towards this end, agencies must first identify the risk factors and needs of the populations that they serve. Next, agencies must use their knowledge and experience, along with data and information from credible sources in order to select or develop effective HIV/AIDS education and prevention strategies for those populations. Then, agencies are advised to look at all possible funding resources in order to develop a comprehensive funding strategy that, whenever possible, is not dependent on any single source of funding. This is both prudent and necessary.

While the NNPC and CPG SoN are committed to providing HIV/AIDS education and prevention services through community agencies, it is important to point out that it also has a responsibility to create and foster creation of such efforts that are sustainable for the long-term. It is important that any strategic plan by community organizations, as well as any from the NNPC and CPG SoN, reflect any changing community needs and changes in the epidemic. Thus, all such plans shall include the most current surveillance data, and community planning data, and that such plans address program development, and training and technical assistance for organizations and their paid and/or unpaid personnel.

II. TECHNICAL ASSISTANCE AND CAPACITY BUILDING PLAN

Building the capacity of the organization and the effectiveness of its programs through training and technical assistance are the activities described here. The NNPC and CPG SoN developed the following plan through much discussion and assessment.

A. Goals

1. To increase the capacity of the community, and specifically community-based organizations serving at-risk and high risk populations in Nevada, to address HIV/AIDS education and prevention with broad (across populations and subgroups) and in-depth (multi-level and culturally sensitive) effective intervention strategies.

2. To assist a wide range of community-based agencies with developing high quality services designed to have long-term sustainability.

B. Objectives

1. Increase capacity of agencies to carry out effective education and prevention programs and maintain organizational stability by:
   a. Enhancing internal operations, organizational leadership and resource development; and
   b. Enhancing program development and evaluation.

2. Reduce redundancy and increase cooperation, sharing of resources, joint ventures and group problem solving among agencies with related purposes by:
   a. Producing a newsletter regarding HIV/AIDS education and prevention services that will be distributed throughout the community, and posted on the Internet and will be funded by HIV/AIDS Prevention related funds *(in Northern Nevada);*
   b. Establishing within the NNPC and CPG SoN "Training and Education Committees" that will assist community agencies with identifying needs, locating free or low-cost resources, coordinating training and technical assistance, and promoting the availability of these services to agencies throughout Northern Nevada;
   c. Creating regional prevention links or web sites (where appropriate) containing information regarding HIV/AIDS, and sexually transmitted disease prevention, and links to resources (i.e., reports, and other information) regarding funding, surveillance data, program planning and evaluation, non-profit management and related issues, and other topics related to creating, and maintaining effective, sustainable organizations and programs; and
   d. Creation of an Agency Fact Sheet for all funded providers designed to increase clients and potential clients awareness of services and eligibility requirements (to be posted on the new web site described in Objective 2-c).

3. Increase the level of resources available within the community for HIV prevention by:
   a. Maintaining and, when possible, promoting additional support of the public sector -- national, state, county, municipalities; and
   b. Generating and maintaining private funding initiatives.

4. Build and maintain respect for the different roles and responsibilities of the NNPC and CPG SoN and its members, and community providers of HIV/AIDS education and prevention services (i.e., individuals, community agencies and institutions which provide services).

C. Roles and Responsibilities

1. Counties
   - Collaborate with national, state, local and community partners to determine the most effective means for implementing HIV education and prevention;
   - Promote linkages and cooperation among representatives of high-risk or infected communities, local community HIV prevention services providers, public health agencies, and behavioral and social scientists who are either in the local area or who are familiar with local prevention needs, issues and at-risk populations;
   - Provide HIV/AIDS surveillance and other relevant data and analyses of national, statewide, regional findings;
   - As necessary, carry out prevention strategies for underserved or emerging risk populations, including those community-level interventions for which no single agency or provider is available or capable;
   - Act as a central point for collection of information and provide referrals and/or information to persons requesting information regarding HIV and AIDS;
   - Ensure program effectiveness through specific evaluation activities;
   - Monitor contractor activities and document contractor compliance.

2. Community Agencies
   - To the greatest extent possible, represent the needs and interests of the communities which they serve;
   - Build the capacity to operate programs and organizations effectively;
   - Strive to increase and maintain a high degree of self-sufficiency, independence and organizational integrity;
   - Establish and maintain short-term and long-term plans which build on the organizational strength and addresses potential weaknesses;
   - Validate use of public resources and specific allocation decisions by conducting evaluations and demonstrating program outcomes;
   - Participate in a community planning process to:
     - ✓ Continue to assess the present and future extent, distribution and impact of HIV/AIDS in defined populations in the community;
     - ✓ Continue to assess the community's capacity to respond to the epidemic, including possible technical assistance needs of local agencies engaged in or interested in engaging in prevention services;
     - ✓ Identify unmet HIV prevention needs;
     - ✓ Define the potential impact of specific education approaches and interventions to prevent new infections;
     - ✓ Update the prioritization of HIV prevention needs;
     - ✓ Assist in the implementation of the elements of a comprehensive HIV Prevention Plan; and,
     - ✓ Assist in evaluating the effectiveness of the planning process;
   - Cooperate fully to develop agreement and then fulfill any obligations and requirements associated with public funding.

3. Nevada State Health Division
    - Provide technical assistance to local public and private agencies to plan, develop, implement and evaluate effective education and prevention programs in accordance with the priorities established by the community planning process;
    - Broaden the capacity of the community to provide HIV education and prevention by supporting collaborations between existing HIV education and prevention agencies and by identifying and encouraging organizations to pursue proactive strategies within their current program activities;
    - Establish and maintain a community planning process which allows for representation which reflects the population characteristics of the current epidemic in Nevada in terms of age, race/ethnicity, gender, sexual orientation, geographic distribution and HIV exposure category; and,
    - Coordinate and manage public funds from a variety of sources to prevent HIV transmission and reduce associated morbidity and mortality.

D. Technical Assistance and Capacity Building Needs

In order to accomplish these goals and objectives, there is a need for technical assistance and training to build skills and knowledge among persons who will impact community-based agencies that provide HIV/AIDS prevention and education services.

Topics that such technical assistance will address, include those directly addressing the organizations' and individuals capacity to provide HIV/AIDS education and prevention services, such as developing strategies for providing multi-level interventions with individuals, groups and communities, and developing culturally appropriate interventions.

In addition, technical assistance services will also be offered to organizations and individuals in order to address other critical factors that impact the provision of HIV/AIDS education and prevention services. Such topics related to improving the organizational capacity to provide services may include: leadership development regarding persons working as manager or on the board of directors; human resource development, such as staff/volunteer recruitment, motivation and retention; operational and financial management; fund raising, and/or financial development/planning; strategic and long-range planning; and, advocacy and policy development.

E. Activities

The following activities will be implemented as a part of this approach.

1. The NNPC and CPG SoN will hire one or more independent contractors (i.e., individuals or agencies) to assist NNPC-funded community agencies to identify the most efficient and effective approaches to meeting their program goals related to HIV education and prevention, building long-term organizational stability and overcoming any barriers to successfully achieving their HIV education and prevention activities. This technical assistance activity will have no relationship to the allocation process. Initially, the NNPC will establish a six-month contract with the independent contractor(s) and continuation of their work beyond this initial period of time will be based on the degree to which it is used and evaluated as useful by the community agencies.

2. Additional training and technical assistance for which the NNPC will be responsible will include the following activities:

Community Health Outreach Worker (CHOW)/Health Educator (HE) Training

The NNPC will offer a certification program for new CHOW's and HE's. This program will include AIDS 101 information, basic outreach and street skills, cultural sensitivity and information on referral resources in the community. New CHOW and HE staff will be expected to successfully complete this course within six months of being hired by a community-based agency wishing to utilize these persons to conduct outreach or educational HIV/AIDS prevention and/or educational services. *(Northern Nevada Only)*

Program Development

The NNPC and CPG SoN will coordinate the provision of training and technical assistance to help agencies build more effective programs by improving existing prevention strategies and expanding services to include more group, individual, and community-level interventions. The NNPC will also coordinate the assistance of agencies to design program delivery systems, evaluation activities and methods to reach hard-to-reach communities.

Collaboration and Coordination

The NNPC and CPG SoN will work with agencies that want to develop collaborative programs to design, implement and evaluate these projects. Additionally, the NNPC and CPG SoN will provide opportunities for agencies involved in education and prevention to share information, receive updates and information on current issues and solve problems collectively.

Dissemination of Information and Resources Available for Free or at Low Cost

The NNPC and CPG SoN will collect, and make widely available to persons who provide HIV/AIDS education and prevention services, materials on issues and concerns relevant to the provision of education and prevention services to a wide range of populations. This will include information about other training and technical assistance resources available to agencies serving Northern Nevada. The NNPC will produce a newsletter a minimum of four times per year and will offer community forums at least twice per year which cover topics of special interest to persons providing HIV/AIDS education and prevention services (i.e., outreach workers or health educators), and to persons managing, or overseeing programs or agencies that provide such services (i.e., members of boards of directors, program directors, or supervisors).

Application Assistance

The NNPC and CPG SoN will assist any organization which submits a letter of intent as part of the application process to determine how the education and prevention goals of that

agency fit within the current local HIV Prevention Plan and will assist in the development of an appropriate program design, and will provide the necessary assistance so that the agency may complete the application process. Assistance will be provided to individuals and/or groups and will assure that no single agency has an advantage over any other agency in completing the application process.

Current Technical Assistance Resources Available

Local resources for technical assistance available within Nevada include:
AIDS Health Education and Training Centers
American Red Cross

Additionally, the NNPC and CPG SoN have developed the following list of technical assistance resources currently available for free or at low cost to persons and/or organizations in Nevada. This list was used to assist each regional group determine gaps in available technical assistance that should be filled to ensure the delivery of effective HIV prevention programs.

Best Practices

The **Joint United Nations Programme on HIV/AIDS (UNAIDS)** has published an extensive range of materials on a variety of topics related to HIV/AIDS, including a collection of best practice materials on about 50 specific topics relevant to HIV/AIDS.
http://www.unaids.org/bestpractice/index.html

The **Maternal and Neonatal Health (MNH) Program** was established in 1998 as USAID's flagship initiative to reduce maternal and newborn deaths in the developing world. The site details the specific clinical interventions that the Program promotes through its training, behavior change and policy efforts, and outlines the Program's crosscutting approaches to improving maternal and neonatal healthcare.
http://www.mnh.jhpiego.org/index.asp

The **Prevention and Early Intervention Web Page of the Center for Effective Collaboration and Practice** is intended to provide prevention practitioners with information on best and promising practices by linking to programs that have been identified by groups of experts as "best practices." The National Institute on Drug Abuse, the Center for Substance Abuse Prevention, and the Office of Juvenile Justice and Delinquency Prevention have all developed lists that are represented here.
http://cecp.air.org/prev-ei/best.htm

The **National Alliance to End Homelessness** highlights program models, state and local policies, and advocacy efforts that are taking positive steps toward the goal of ending homelessness. Discusses programs that move chronically ill and homeless people out of homelessness by providing permanent supportive housing.
http://www.endhomelessness.org/best/index.htm

Budgeting

The Foundation Center offers **Proposal Budgeting Basics**, an online tutorial designed to clarify the basics of developing a project budget.
http://fdncenter.org/learn/classroom/prop_budgt/index.html

The Office of Research Development at the University of Texas at San Antonio has created a general overview of budgeting concepts and generally accepted layout for inclusion in grant applications.
http://www.utsa.edu/research/Proposal%20Development/proposal_budget.htm

An article entitled **Converting the Enemy: Budgeting During Planning** written by Juliana Grenzeback for The National Endowment for the Arts: Lessons Learned: Essays, seeks to de-mystify the budgeting process and offers advice on grounding the budget in reality.
http://arts.endow.gov/pub/lessons/Lessons/GRENZEBACK.HTML

Community Planning Web Sites

Centers for Disease Control and Prevention: Division of HIV Prevention has several publications for HIV prevention and community planning.
http://www.cdc.gov/hiv/pubs.htm

The **National Minority AIDS Council (NMAC),** established in 1987, is the premier national organization dedicated to developing leadership within communities of color to address the challenges of HIV/AIDS. NMAC works to influence public policy, provides treatment education, training and advocacy and offers technical assistance, through planning initiatives and publications.
http://www.nmac.org/tech/tech.htm

HIV InSite from the University of California at San Francisco provides an extensive section on HIV community planning.
http://hivinsite.ucsf.edu/InSite.jsp?page=pr-02-03

Computers

AnotheR BytE has been recycling older computers from across America since 1994, providing low or no-cost computers, computer instruction, and technical services to organizations and individuals in need.
http://www.recycles.org/byte/index.htm

Cultural Competence

The **National Center for Cultural Competence** of Georgetown University seeks to increase the capacity of health care and mental health programs to design, implement, and evaluate culturally and linguistically competent service delivery systems. The Center offers training, technical assistance and consultation, networking, linkages and information exchange, and knowledge and product development and dissemination.
http://www.georgetown.edu/research/gucdc/nccc/

The **National Center for Cultural Healing**, located in Virginia, provides training and education in cultural diversity.
http://www.culturalhealing.com/index.htm

The Office of Affirmative Action at the University of Iowa has produced the **Cultural Competency Bibliography.**
http://www.uiowa.edu/~oaa/bib1.htm

The **Center for Cross Cultural Health** trains health and human service providers and organizations in the State of Minnesota and beyond. The Center is also a research and information resource, working to develop culturally competent individuals, organizations, systems, and societies.
http://www.crosshealth.com/index.html

Collaboration

This site, **Building Community Collaboration and Consensus (**created by .R. Pete Petersen, M.Ed.) provides practical information for building collaboration and partnerships, locating assets and resources, developing and completing goals and objectives and achieving success.
http://www.communitycollaboration.net/

Conflict Resolution

Sponsored by Amazon.com this site offers **Bibliographies and Books on Conflict Resolution**.
http://www.geocities.com/Athens/8945/biblio.html

Decision Making

Consensus
This page of the ACT UP website outlines **Consensus Decision-making.**
http://www.actupny.org/documents/CDdocuments/Consensus.html

Consensus - How to and Why is a brief guide to organizing your group with consensus proceedings. (Michigan State University)
http://www.msu.edu/~corcora5/org/consensus.html

Evaluation

The Measurement Group site presents evaluation tools and instruments, and evaluation and research studies on various topics related to HIV/AIDS care and services. A selected set of resource materials contained in different sections of the web site that will be of special interest to HRSA Ryan White CARE Act Grantees from Titles I, II, III, IV, SPNS, and the AETCs.
http://www.tmg-web.com/index.htm

Largely based on the work of the United Way of America's book, *Measuring Program Outcomes: A Practical Approach* (1996), this on-line guide - **Basic Guide to Outcomes-Based Evaluation for Nonprofit Organizations with Very Limited Resources** written by Carter McNamara, MBA, PhD -summarizes basic planning and implementation of an outcomes-based evaluation process in nonprofit organizations. This document provides basic guidance -- particularly to small nonprofits with very limited resources. Has useful links to other evaluation overviews.
http://www.mapnp.org/library/evaluatn/outcomes.htm

Released in March 2002, the **Evaluation Guidance Handbook: Strategies for Implementing the Evaluation Guidance for CDC-Funded HIV Prevention Programs** is a good resource for understanding process and outcome measures and ways to plan an effective data collection and reporting system. Though designed specifically to evaluate health department HIV Prevention activities funded by CDC, the information can be helpful. The CDC is in the process of creating a similar guide designed specifically for CBOs.
http://www.cdc.gov/hiv/aboutdhap/perb/guidance.htm

HRSA has developed **Outcome Evaluation Technical Assistance Guides** that provide a general overview of outcome-based assessments for Ryan White HIV services. There are two comprehensive guides for case management and primary care services.
http://hab.hrsa.gov/tools/outcomeguides.htm

The **W.K. Kellogg Foundation Evaluation Handbook** provides a framework for thinking about evaluation as a relevant and useful program tool.
http://www.wkkf.org

Management

CompassPoint Nonprofit Services is a nonprofit training, consulting and research organization with offices in San Francisco and Silicon Valley. Through a broad range of services, they provide nonprofits with the management tools, concepts and strategies necessary to shape change in their communities.
http://www.compasspoint.org/

The Management Center, a leading resource for nonprofit management support in Northern California, helps nonprofit organizations achieve there full potential through effective consulting, training and information resources. The Center assists nonprofit leaders in strengthening their organizations and enhancing their community service.
http://www.tmcenter.org/

The Alliance for Nonprofit Management is the professional association of individuals and organizations devoted to improving the management and governance capacity of nonprofits - to assist nonprofits in fulfilling their mission. The Alliance's greatest strength is its network of members, a diverse group of colleagues exchanging resources, ideas, challenging questions and solutions, and working together to rise up to a higher level of quality in nonprofit capacity building. Dues are minimal. The site hosts the Alliance Resource Center - a comprehensive compilation of websites, books, videos and other valuable resources relating to nonprofit management.
http://www.allianceonline.org/

C-MAP, the California Management Assistance Partnership, is a consortium of 14 regional, nonprofit support organizations providing training and technical assistance to local nonprofits. C-MAP maintains the **Nonprofit GENIE** website as a free service to help nonprofit staff and board members manage more successfully. The site offers numerous resources and links to other sites.
http://www.genie.org/

Developed by Carter McNamara, Authenticity Consulting, LLC the **Free Management Library** offers an index of 675 topics of relevance for nonprofits and for profits.
http://www.mapnp.org/library/

The **National Council of Nonprofit Associations** (NCNA) is a network of 37 state and regional associations of nonprofits representing more than 21,000 nonprofits throughout the country. NCNA serves as the "eyes, ears and voice" of the state associations, assuring that key national information is disseminated at the local level and local concerns are raised at the national level.
http://www.ncna.org/

NPIN FAX is the fax-on-demand service of the CDC National Prevention Information Network (NPIN), available 24 hours a day. NPIN FAX provides access to numerous reports, fact sheets, and other documents related to HIV, STD and TB prevention.
http://www.cdcnpin.org/services/faxpubs.htm

The **Funding Information Center** is a resource for **North Texas** not-for-profit organizations. FIC programs include a free, self-service library of research materials on grants, fundraising, and nonprofit management; a directory of Tarrant County grantmakers; workshop, audio conference, videoconference, and forum learning opportunities; a Partnership Program for nonprofit charities and foundations; and information and referral services for Center Partners.
http://www.fic-ftw.org/links.htm

Local Independent Charities of America is a federated group representing charitable organizations that specialize in areas such as feeding the hungry, sheltering the homeless, protecting children, healing the sick, and defending animals, as well as helping to inform, educate, and empower people across the nation. Its mission is to organize and prepare its member charities for effective participation in at-work employee charitable fund drives, to screen and certify these charities to ensure they meet the eligibility criteria to participate in these fund drives, to help educate contributors about the work of these worthy causes, and to provide for the secure, accurate, and timely transmission of contributions from the fund drives to the recipient charities.
http://www.lic.org/

The **NonProfit Gateway** is a central starting point to help nonprofit organizations access online Federal information and services. Linked to all Cabinet Departments and many agencies, it contains information about grants, regulations, taxes, and other services, as well as information on a wide range of other topics and programs.
http://www.nonprofit.gov/

The **Internet Nonprofit Center** is a project of The Evergreen State Society based in Seattle, Washington, USA. The Internet Nonprofit Center is the home of the Nonprofit FAQ. The FAQ is based on "frequently asked questions" – and their answers – drawn from the 'Nonprofit' email discussion forum (see http://www.rain.org/mailman/listinfo/nonprofit) and other online resources. Its editor is Putnam Barber.
http://www.nonprofits.org/

Hiring, Recruitment & Employment

Opportunity NOCs, is a comprehensive, national job database containing hundreds of nonprofit job listings for administrative, staff and professional positions.
http://www.opportunitynocs.org/

Financial Management

Basic Guide to Non-Profit Financial Management written by Carter McNamara, MBA, PhD for the Free Management Library, this site outlines basic practices in financial management, and documents the basic systems and practices needed in a healthy business.
http://www.mapnp.org/library/finance/np_fnce/np_fnce.htm

The mission of the **Nonprofit Financial Center** is to strengthen the viability of communities by enhancing the financial stability and management capacity of the nonprofits, individuals, and organizations that support those communities. Offers financial management training, consulting services and informational resources.
http://www.nfconline.org/

Fund Raising

The Association of Fundraising Professionals, an association of professionals throughout the world, advances philanthropy by enabling people and organizations to practice effective and ethical fundraising. The core activities through which AFP fulfills this mission include education, training, mentoring, research, credentialing, and advocacy.
http://www.afpnet.org/index.cfm

The Grassroots Fundraising Journal helps nonprofit organizations learn how to raise more money to support their important work. Published bi-monthly, the Journal offers practical, how-to instruction on fundraising strategies such as: direct mail, special events, major gift campaigns, and phone-a-thons, as well as tools to help you build a board of directors that is willing to raise money, choose a database to track donors, manage your time effectively, and ultimately develop a successful fundraising program. Six issues /year for $32.
http://www.grassrootsfundraising.org/about.html

All Fundraising Companies Directory lists over 1200 independent companies offering traditional, unique, and sometimes bizarre fundraising ideas and fundraising products.
http://www.fundraisingweb.org/

HIV/AIDS Mega Sites

The **AIDS Education Global Information System (AEGiS)** was conceived in the mid-1980s, as a global informational response to the global AIDS pandemic. AEGiS provides access to timely, correct information about treatment advances, drug interactions and other important issues relating to HIV infection and AIDS. AEGiS uses both a web site and an email list server, the latter to reach those not having access to the Web.
http://www.aegis.org/

HIV Prevention Planning Mega Site

The **National Alliance of State and Territorial AIDS Directors (NASTAD)** represents the nation's chief state health agency staff who have programmatic responsibility for administering AIDS health care, prevention, education and supportive service programs funded by state and federal governments. NASTAD provides national leadership in HIV/AIDS public policy and funding and promotes communication between state and local health departments and HIV/AIDS prevention and care programs.
http://www.hivaidsta.org/

HIV InSite from the University of California at San Francisco provides comprehensive, up-to-date information on HIV/AIDS treatment, prevention and policy.
http://hivinsite.ucsf.edu/InSite.jsp

CDC National Prevention Information Network links to on-line resources with additional information on HIV/AIDS/STD and TB, as well as various reference tools.
http://www.cdcnpin.org/rellinks.htm#african

Internet Assistance

Web Design Pros provides the Internet community, especially nonprofit organizations and small businesses, with affordable alternatives for advertising and promotion on the Internet. The website highlights information on fund raising, nonprofit organization management, and much more.
http://www.webdesignpros.net/nonprofit/npdirectory.htm

On-Line HIV/AIDS Information

John La Bella first prepared this slide show on **"How to Find HIV and AIDS Information on the Internet"** for a Massachusetts Department of Public Health AIDS conference, and later taken on a tour of PWA groups, hospitals, and living centers.
http://www.infoweb.org/library/access/find_aids_info/index.htm

Proposal Writing

The Foundation Center's **Proposal Writing Short Course** is a free two-part online course covering the basic components of a proposal and important elements such as budget and expenses, administration, and the research process involved in writing a proposal.
http://fdncenter.org/learn/shortcourse/prop1.html

Grantproposal.com, developed by Elizabeth Brunner a grantwriter at California Polytechnic State University, provides a comprehensive overview of the grantmaking process (including advice from funders), tips for developing proposals, sample letters of inquiry and proposals, and links to numerous web and print resources for proposal development, prospect research.
http://grantproposal.com/

Non-Profit Guides: grantwriting tools for non profit organizations, published by SeaCoast Web Design, offers a very comprehensive and detailed step by step guide for all aspects of proposal development.
http://www.npguides.org/index.html

With helpful writing hints and examples, the website, **Guide For Writing A Funding Proposal,** by S. Joseph Levine, Ph.D., Michigan State University, provides a straightforward and useful guide for the major components of a proposal.
http://www.learnerassociates.net/proposal/

After a review of over 300 grant-related documents, developed by Westinghouse Electric and the U.S. Department of Energy Carlsbad Area Office developed the **Grant Self Assessment Tool (GrantSAT)** to help organizations evaluate their proposals prior to submission.
http://www.orsp.cmich.edu/pdf/grantsat.pdf

Search Engines

This website sponsored by the ChanRobles Group lists all the **Major Search Tools of the Web**.
http://www.chanrobles.com/engines.htm

All Search Engines.com lists major search engines and categorizes search engines by topic.
http://www.allsearchengines.com/

State Planning Groups

Massachusetts	http://www.state.ma.us/dph/aids/MPPGDESC.HTM
Michigan	http://www.mihivnews.com/statewide.htm
Ohio	http://www.wayne-health.org/aids_consortium2.html
Washington	http://www.doh.wa.gov/cfh/HIV_AIDS/prev_edu/spg.htm

CHAPTER 10: EVALUATION

Evaluation of Planning Process: Overview

The evaluation of the process of developing a plan for HIV prevention in Nevada coincided with the planning process, from March 2001 through mid-September 2002. The external evaluator attended several scheduled monthly CPG SoN planning meetings. External evaluation did not occur for the NNPC. External evaluation was based on both observation and assessments conducted by survey at each meeting.

The Evaluation Plan for the State of Nevada includes seven sections:
1) Evaluating the HIV Prevention Community Planning Process
2) Designing and Evaluating Intervention Plans
3) Monitoring and Evaluating the Implementation of HIV Prevention Programs
4) Evaluating Linkages Between the Comprehensive HIV Prevention Plan and Resource Allocation
5) Monitoring Outcomes of Health Education/Risk Reduction Individual- and Group-Level HIV Prevention Activities
6) Evaluating Outcomes of HIV Prevention Programs, and
7) Monitoring the Impact of HIV Prevention Programs.

Each section describes the evaluation activities that will be conducted in order to meet the criteria established in the CDC Evaluation Guidance.

1. Evaluating the HIV Prevention Community Planning Process

During the 2002 calendar year, the Southern Nevada (CPG SoN) and Northern Nevada Community Planning Group (the NNPC) engaged in a community planning process, which culminated in the development of a REVISED Comprehensive HIV Prevention Plan for the State of Nevada. A community-planning consultant assisted with this statewide planning process. The evaluation of the planning process in 2002 included an external review as required by the Centers for Disease Control and Prevention (CDC) to determine the extent to which the development of a Comprehensive HIV Prevention Plan adhered to the CDC guidelines and if it is deemed to be fair and appropriate by participants in the process.

The full report can be found in Attachment 6. A summary of the report is noted below:

The external evaluation for the CPG SoN addresses the following four Core Objectives developed by CDC for the community planning process:

- Core Objective 1: Foster the open and participatory nature of the community planning process;
- Core Objective 2: Ensure that the community planning group reflects the diversity of the epidemic in the jurisdiction, and that experts in epidemiology, behavioral sciences, health planning, and evaluation are included in the process;

- Core Objective 3: Ensure that priority HIV prevention needs are determined based on an epidemiologic profile and a needs assessment; and
- Core Objective 4: Ensure that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, social and behavioral science and theory, and community norms and values.

To evaluate these core values a number of methods were incorporated in the development of this report including:

- Personal observation of the Process within the period of this report;
- Random surveying of Co-chairs and Members of the CPG SoN throughout the period of this report;
- Surveying of Co-chairs and Members at the conclusion of the planning year, January 2002 and again in August 2002;
- Review of the CPG SoN bylaws to determine the extent to which there are written processes, policies and/or procedures adherent to CDC Guidelines; and
- Review of the official minutes of the planning group.

Findings:

Core Objective 1: Foster the open and participatory nature of the community planning process.

Analysis of this core objective has identified the availability of the following documentation to support adherence with CDC guidelines:

- Bylaws outlining:
  - Nomination and selection criteria for membership;
  - Meeting attendance criteria; *and*
  - Conflict Resolution procedures;
- Meeting Agendas and Minutes inclusive of:
  - Public Comment/Open Discussion
- New Member Orientation
- Membership Survey documenting:
  - Facilitation of member participation; *and*
  - Members' perspectives on the process.

Areas that are not addressed, or are in need of greater clarity:

- Membership recruitment
- Orientation procedures
- Input from non-CPG SoN members
- Member training

Conclusion:

The evaluative outcome of the open and participatory nature of the CPG SoN's planning process is best articulated by the qualitative data reported in the January 2002 and August 2002 surveys of its membership:

"The board maintains a positive approach to HIV/AIDS Prevention. Members are consistently participatory and consistently attempting to increase their knowledge base as well as their ability to make an impact in this fight against HIV/AIDS Prevention."

"The formulation of CPG SoN members was comprised of people from many different backgrounds and disciplines. In that the main focus of this board underscored strategies designed to eradicate HIV/AIDS, that has spear headed the drive as well as maintained cohesiveness in the board in a very positive way."

"The planning group works very well together. Egos are left at the door. Excellent leadership Jason, CCHD."

This data is further supported with quantitative data collected in August 2002 and described below suggesting that while there are areas with a need for improvement, the CPG SoN has met this objective and the Northern Nevada Group is making progress. A complete description of the survey is included in Attachment 7.

Team Performance Self Evaluation
Northern Nevada Community Planning Group
August 2002

	Average	%	SEM
Feeling of Community	17.7	68.0	2.1
Mobilization Capacity	23.4	76.7	2.9
Readiness for Action	25.1	83.7	2.7
OVERALL TOTAL	**65.2**	**76.7%**	**16.5**

Team Performance Self Evaluation
Southern Nevada Community Planning Group
August 2002

	Average	%	SEM
Feeling of Community	22.7	90.8	22.7
Mobilization Capacity	26.7	89.0	1.1
Readiness for Action	18.4*	92.0	0.7
OVERALL TOTALS	**67.9**	**90.5**	**5.7**

***** The survey form completed by Southern Nevada members contained only four items in the Readiness For Action section.

Core Objective 2: Ensure that the community planning group reflects the diversity of the epidemic in the jurisdiction, and that experts in epidemiology, behavioral science, health planning, and evaluation are included in the process.

The data utilized to evaluate this core objective was provided by the Clark County Health District, contained with the CDC report Community Planning Group Membership Grid, Tables 1 – 9b. On the offset, primary and secondary representation is adherent to CDC guidance on representation of experts in the areas of epidemiology, behavioral science, health planning, and evaluation.

Analysis of the reflectiveness of the membership of the epidemic within the planning jurisdiction identifies some disparities. These disparities begin with gender. Males make up 82.7% of the epidemic within the planning jurisdiction while males represent 43.5% of the CPG SoN membership. Females represent 17.3% of the epidemic, representation of females on the CPG SoN account for 52.2% of its membership. When examining Representation by Race, an 11% disparity of representation of the African American community is identified between the CPG SoN and the epidemic. The PLWHA community has a representation of 4.3% of the CPG SoN membership. Risk category data was not collected from CPG-SoN members. Evaluation of reflectiveness in this area cannot be conducted.

Groups not represented on the CPG SoN include, rural populations, the Faith Community, Epidemiologist, American Indian or Alaska Natives, native Hawaiian or other Pacific Islanders, and individuals of mixed race.

This analysis is further recognized by the membership who reporting a slightly less than Somewhat Agree (2.8 mean) that '*the Community Planning Process reflects the diversity of the epidemic in the jurisdiction*.' Further, the membership of CPG overall Strongly Disagree to Somewhat Disagree (1.5 mean) that '*there is an adequate mix of people infected with and affected by HIV/AIDS on the CPG*'

Conclusion:
Without more demographic data being collected on the membership of the CPG SoN, a guarded approach to the evaluative outcome of this Core objective is required. Representation of the expertise required by CDC Guidelines is achieved, while greater focus on gender, ethnic and racial, and PLWHA representation require greater emphasis. Further, to accurately evaluate the reflectiveness of the CPG SoN with the planning jurisdictional epidemic, risk category information should be collected during the application and nominations process.

Core Objective 3: Ensure that priority HIV prevention needs are determined based on an epidemiologic profile and a needs assessment.

The CPG SoN conducted a process of setting priorities of target populations utilizing quantitative and qualitative data. This was achieved with up-to-date epidemiologic data and available needs assessment data provided by the Clark County Health District. It is important to note however, that a completed Epidemiologic Profile and Needs Assessment were not available to the CPG SoN membership at the time of setting the priorities.

Conclusion:
A review of the priorities of comprehensive plan should be conducted utilizing the completed Epidemiologic Profile and Needs Assessment reports to assure that the prioritization is in line with the determinations and conclusions of these documents.

Core Objective 4: Ensure that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, social and behavioral science and theory, and community norms and values.

The CPG SoN conducted a process in the prioritization of interventions that included a review of programs demonstrating cost effectiveness and outcomes in the prevention of HIV, community norms and values, needs of each prioritized target population, and qualitative and experiential data of the members.

Conclusion:
With the diverse educational background of the CPG SoN members, this process, with ongoing evaluation of programmatic implementation and provision, should prove to be a practical process that is flexible in addressing the future prevention needs of those at-risk within the planning jurisdiction.

During the 2003 calendar year, the SoN and the NNPC will engage in planning activities as identified in the Comprehensive HIV Prevention Plan. These planning activities will be evaluated in the following manner: 1) collecting demographic data from CPG members, developing a CPG member database, and directory of CPG members; 2) administering meeting evaluation forms to CPG members at the conclusion of CPG meetings; and 3) conducting an annual CPG member survey, intended to assess CPG member satisfaction and perception on progress toward objectives and the implementation of the Nevada HIV Prevention Plan.

Evaluation at the Nevada State Health Division HIV/AIDS Program:
The Nevada State Health Division HIV/AIDS Program plans to hire a full-time Evaluation Coordinator during the 2003 calendar year in order to implement many of the evaluation activities described in this plan. The specific responsibilities of the Evaluation Coordinator are described below.

2. Designing and Evaluating Intervention Plans

Brief Description of Evaluation Activity per the CDC Evaluation Guidance: Process used to review proposals and assess plans for implementing proposed interventions in order to improve interventions before they are implemented.

The Nevada State Health Division HIV/AIDS Program plans to implement the following activities in order to meet the criteria established in the CDC Evaluation Guidance with regard to designing and evaluating intervention plans: a) Request for Proposal (RFP) Process; b) Evaluation Training Program (ETP); and c) Contract Monitoring. These activities are described below.

a) Request for Proposal (RFP) Process

In an effort to ensure that funded interventions are relevant and scientifically sound, the NSHD will require, via the RFP process, that all interventions meet intervention criteria identified in the Guidance. Grantees will be required to include the information requested on the intervention plan forms (Chapter 3 of the Evaluation Guidance, Volume 2) in their RFP applications. In addition, the RFP process will encourage applicants to implement the intervention types that were identified as priority interventions for each target population in the HIV Prevention Plan. This emphasis on

priority interventions is also discussed in Section IV, "Evaluating Linkages Between the Comprehensive HIV Prevention Plan and Resource Allocation."

b) Evaluation Training Program (ETP)

Once funded, grantees will attend a two-day Evaluation Training Program. The NSHD Evaluation Coordinator and/or a technical assistance consultant will conduct this training. During the ETP, grantees will be provided an overview of Nevada's Evaluation Plan. Grantees will receive Evaluation Binders that contain specific information about the evaluation processes in which they are required to participate. In addition, they will be instructed to maintain sections of these binders by keeping documentation for their interventions in a specific format. These binders will be reviewed during site visits and/or as requested during the funding period.

The two-day training will cover the following evaluation activities: 1) review and revision of intervention plans; 2) participation in the web-based data entry system used to collect process monitoring data; 3) site visits; and 4) participation in outcome monitoring projects. During this training, each grantee will meet one-on-one with the Evaluation Coordinator to review and, if necessary, revise their intervention plans. The Evaluation Coordinator, drawing upon input from the grant review committee and the Nevada HIV Prevention Plan, will make recommendations prior to implementation in an effort to improve interventions before they are implemented. Grantees will also be trained to utilize the web-based data entry system in order to enter process monitoring data for their interventions. In addition, grantees will be informed about the purpose and scope of the site visit process. Finally, the ETP will include training related to the outcome monitoring projects (discussed below in Section V, "Monitoring Outcomes of Health Education/Risk Reduction Individual- and Group-level HIV Prevention Activities"). Grantees participating in these projects will be trained to collect pre-test/post-test data. If the web-based data entry system is expanded to include the entry of this data, grantees will be trained to enter pre-test/post-test outcome monitoring data.

c) Contract Monitoring

In an effort to ensure that interventions are being implemented in accordance with their respective intervention plans, the Evaluation Coordinator and the NSHD HIV Prevention Coordinator will engage in the following contract monitoring activities: 1) desk reviews of quarterly reports; 2) site visits twice per year with all grantees, focusing on review of progress on intervention plans; and 3) participation in Evaluation Review Meetings (ERMs) on a quarterly basis. During quarterly ERMs, the Evaluation Coordinator will meet with the following individuals: the NSHD HIV Prevention Coordinator, the NSHD HIV/AIDS Program Manager, the NSHD Grants and Project Analyst, the CCHD HIV Prevention Coordinator, and the WCDHD HIV Prevention Coordinator. During these meetings, these individuals will review 1) the implementation of Nevada's HIV Prevention Plan; 2) contract monitoring data, 3) site visit data (if available); 4) process monitoring data, and 5) other relevant evaluation data required of grantees. (ERMs are also described below in Section IV, "Evaluating Linkages Between the Comprehensive HIV Prevention Plan and Resource Allocation").

3. Monitoring and Evaluating the Implementation of HIV Prevention Programs

In the past, the Nevada State Health Division has evaluated the implementation of HIV prevention programs by requiring the funded agencies to submit Prevention Activity Reports (PARs). While these forms have included important process monitoring data, they do not permit collection of all the data needed for this type of evaluation. Furthermore, they do not collect this data in the format needed to complete the Process Monitoring forms (Chapter 4 of the Evaluation Guidance). Therefore, the Nevada State Health Division HIV/AIDS Program plans to develop a web-based data entry system for process monitoring data in order to meet the criteria established in the CDC Evaluation Guidance. A web-based data entry system will make it possible to collect Process Monitoring data in a standardized format on a statewide basis.

A web-based data entry system for process monitoring data will be piloted in Fall 2002 in an effort to have it operational by January 2003. In order to pilot this system, grantees funded in CY2002 will be trained (in late October 2002) to access the web-based data entry system and enter process monitoring data in the format required in the Guidance. After the system is piloted in Fall 2002, the web-based data entry system will be operational for CY2003. Once funded for CY2003, all grantees will be required to attend a two-day Evaluation Training Program (previously described in Section II, Designing and Evaluating Intervention Plans) in order to learn how to enter process monitoring data into this system. Grantees will enter this data on a monthly basis. The Evaluation Coordinator will maintain the process monitoring database and summarize/interpret this data for quarterly and annual reports. This data will be housed at the Nevada State Health Division.

4. Evaluating Linkages Between the Comprehensive HIV Prevention Plan and Resource Allocation

In addressing the evaluation linkages between the Comprehensive HIV Prevention Plan and resource allocation, it is important to review HIV prevention planning core objective five: "Fostering strong, logical linkages between the community planning process, plans, applications for funding, and allocation of CDC HIV prevention resources." This objective bridges evaluation of the community planning process with intervention plan evaluation by emphasizing the importance of allocating funds for interventions that correspond to recommended interventions in the Comprehensive HIV Prevention Plan. As previously mentioned, the RFP process will encourage applicants to implement the intervention types that were identified as priority interventions for each target population in the Comprehensive HIV Prevention Plan.

In order to evaluate these linkages, the Evaluation Coordinator will follow the steps identified in the Evaluation Guidance: 1) abstract the comprehensive plan; 2) list providers and their current HIV prevention interventions; 3) collect critical information about HIV prevention interventions; and 4) match interventions to recommended interventions strategies in the Comprehensive HIV Prevention Plan.

As mentioned in Section II, on a quarterly basis, the Evaluation Coordinator, the HIV Prevention Program Coordinator, HIV/AIDS Program Manager, the Grants and Project Analyst, the CCHD HIV Prevention Coordinator, and the WCDHD HIV Prevention Coordinator will conduct Evaluation Review Meetings. During ERMs, these individuals will review the abstract of the comprehensive plan, the list of providers and their current HIV prevention interventions, contract

monitoring data, site visit data, process monitoring data and outcome monitoring data. By reviewing, analyzing and discussing this data, ERM members will identify any necessary changes in the evaluation process and/or the implementation of interventions. Ultimately, the ERM process will make it possible to ensure that Nevada's Comprehensive HIV Prevention Plan is being implemented as intended.

5. Monitoring Outcomes of Health Education/Risk Reduction Individual- and Group-Level HIV Prevention Activities

Nevada will conduct outcome monitoring projects in both regions. The Evaluation Coordinator will be responsible for implementing these projects. Grantees with individual- and group-level interventions suitable for outcome monitoring will be trained to collect outcome monitoring data from clients prior to (pre-test) and following (post-test) each intervention. This data will be used to better understand: 1) clients' progress toward behavioral goals and objectives, 2) differential progress within subgroups of clients; and 3) if particular aspects of implementation contribute to or hinder clients' progress. Client outcomes that will be addressed by the outcome monitoring projects fall into the Knowledge, Attitudes, Beliefs and Behaviors (KABB) domains. If grantees are implementing interventions for which there are already valid and reliable evaluation instruments available, these will be used. In cases where there are no valid and reliable evaluation instruments available, the Evaluation Coordinator, in collaboration with grantees, will develop pre-test and post-test instruments for outcome monitoring. During the past three years, grantees in NNPC have utilized instruments developed by an evaluation consultant. These instruments may be adapted for use with outcome monitoring projects.

Grantees will be instructed to protect client identities through the use of unique identification numbers (UINs). Clients will create UINs by answering a pre-established pair of questions (e.g., birth year followed by birth month). UINs will be used on both the pre-test and post-test instruments as to permit comparison between data collected prior to and following an intervention.

If possible, the web-based data entry system will be used to enter outcome monitoring data as well as process monitoring data. During the pilot-testing phase of the web-based data entry system (for process monitoring), the addition of outcome monitoring data will be explored. If this is possible, grantees will enter outcome monitoring pre- and post-test data via the web-based data entry system. If this is not possible in CY 2003, outcome monitoring data will be submitted to the Evaluation Coordinator at the Nevada State Health Division for data entry and analysis. A data entry assistant will enter data into a database housed at the NSHD. The Evaluation Coordinator will analyze and interpret this data and include it in quarterly and annual reports.

6. Evaluating Outcomes of HIV Prevention Program

Outcome evaluation will not be used due to the complex and resource-intensive nature of this approach. Rather, outcome monitoring (described in the section above) is preferred due to the benefits of this approach in HIV prevention programming.

7. Monitoring the Impact of HIV Prevention Programs

The following data will be collected to monitor the impact of HIV prevention programs:

a. HIV/AIDS Surveillance Data [Counseling and Testing System (CTS) data, HIV/AIDS Reporting System (HARS) data]
b. Relevant HIV/AIDS care statistics
c. Behavioral Risk Factor Surveillance Survey (BRFSS) data
d. Youth Risk Behavior Survey (YRBS) data

The Evaluation Coordinator will review this data on a quarterly and annual basis. This data will be provided to CPGs, shared during Evaluation Review Meetings, and included in reports where appropriate.

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GLOSSARY:

affected community: This includes HIV-positive people, persons living with AIDS and other individuals, including their families, friends and advocates, directly impacted by HIV infection and its physical, psychological and sociological ramifications.

AIDS: Acquired Immunodeficiency Syndrome: The most severe manifestation of infection with the human immunodeficiency virus (HIV). The Centers for Disease Control and Prevention list numerous opportunistic infections and neoplasms (cancers), which, in the presence of HIV infection, constitute an AIDS diagnosis. In addition, a CD4+ T-cell count below 200 in the presence of HIV infection constitutes an AIDS diagnosis.

capacity building: creating within an organization the structure and processes which will allow it to function at its best.

CBO: Community-Based Organization: An agency that provides services at the community level.

community prevention planning: This type of planning is evidence based (i.e., based on HIV/AIDS epidemiologic surveillance and other data, ongoing program experience, program evaluation, and a comprehensive, objective needs assessment process) and incorporates the views and perspectives of the groups at risk for HIV infection/transmission for whom the programs are intended, as well as other providers of HIV related services.

cumulative incidence: The total number of cases occurring in a given population over a certain period of time.

demographics: The statistical characteristics of human populations, especially with reference to size, density, distribution, and vital statistics.

empirical: based on experimental data, not on a theory.

epidemic: spread of an infectious disease through a population or geographic area.

epidemiological profile: A description of the current status and projected future spread of an infectious disease (epidemic) in a specified geographic area.

epidemiology: The study of factors associated with health and disease and their distribution in the population. [Epidemiologists study diseases, generally with the intent of finding means of control and prevention. Epidemiology typically addresses such aspects of a disease as its causes, the number of cases, their distribution both geographically and among different populations, and trends in the incidence of the disease.]

exposure category: In describing HIV/AIDS cases, the same as transmission categories; how an individual may have been exposed to HIV.

HIV: Human Immunodeficiency Virus: The retrovirus isolated and recognized as the etiologic (i.e., causing or contributing to the cause of a disease) agent of AIDS.

IDU: Injection drug user.

incidence: The number of new cases of a disease or condition that occur within a given time period. Often incidence is expressed annually, e.g., the number of new cases occurring during a year.

incidence rate: The number of new cases of a disease that occur per population per specified time period, often expressed per 100,000 population.

in utero: in the uterus; before birth.

Knowledge, Attitude, Belief and Behavior (KABB) Studies: Within the AIDS arena, studies which attempt to determine the impact that HIV/AIDS Prevention activities or messages have on: (a) changing the knowledge, attitudes and beliefs about HIV and its transmission; (b) behavior change related to risk factors (such as unprotected sex) of participants.

mean: The arithmetic average, or the sum of all the values divided by the number of values.

median: The middle number in a sequence of numbers, taken as the average of the two middle numbers when the sequence has an even number of numbers.

morbidity: The relative incidence of disease.

mortality: The proportion of deaths to population.

MSM: Men who have sex with men.

needs assessment: Assessment of HIV Prevention needs is based on a variety of sources (both qualitative and quantitative) including resource inventories, focus groups, surveys, key informant interviews and community forums. A needs assessment incorporates information from both providers and consumers of services to obtain an accurate epidemiologic profile of the present and future extent, distribution, and impact of HIV/AIDS in defined, targeted populations.

perceived risk: the perceptions within a given population of their risk for HIV infection (this may not coincide with a population's actual risk for HIV infection).

perinatal: Events that occur at or around the time of birth.

postnatal: Events that occur after the time of birth.

prenatal: Events that occur before the time of birth.

prevalence: The percentage of a population that is affected with a particular disease or condition during a given period of time.(compared to incidence rate which refers to new cases).

primary prevention: Activities that prevent the spread of HIV (or any disease).

public health surveillance: an ongoing, systematic process of collecting, analyzing and using data on specific health conditions and diseases in order to monitor these health problems.

PWA: People with AIDS (sometimes PLWA: People Living With AIDS)

RFP: Request For Proposal: a document describing available funds and the process for applying for these funds.

secondary prevention: Activities that delay the onset of illness in persons with HIV.

Sero-conversion: The development of antibodies to a particular antigen. When people develop antibodies to HIV or an experimental HIV vaccine, they "seroconvert" from antibody-negative to antibody-positive.

seroprevalence: As related to HIV infection: The proportion of persons who have serologic (i.e., pertaining to serum) evidence of HIV infection at any given time.

serostatus: Results of a test for specific antibodies.

TA: Technical assistance includes training, consultation and other support provided to organizations.

target groups: Groups selected for a particular purpose: within the Sacramento County HIV Prevention Plan, the groups were selected due to their risk of exposure to HIV.

transmission categories: In describing HIV/AIDS cases, the same as exposure categories; how an individual may have been exposed to HIV.

trend: A movement in a particular direction in the value of variables over time.

ACROYNM IDENTIFIERS:

HANAS: HIV/AIDS Needs Assessment Survey

HAPSS: HIV/AIDS Prevention Services Survey

PCH: Partnership for Health

PLWH: Person Living with HIV

PLWA: Person Living with AIDS